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ABSTRACT

This document contains a list of planning committee members, institute participants, an introduction by Gerald C. St. Denis, a program agenda, and institute presentations. The following presentations are included: (1) "Greetings" (Barbara K. Shore); (2) "Public Health Social Work in Maternal and Child Health: A Forward Plan" (Alex Gitterman); (3) "Follow-up of High Risk Infants and Their Families--Are They Getting the Services They Need?" (Lynda C. Mulhauser); (4) "Homeless Families, Children and Youth: Address Unknown" (Rita A. Webb); (5) "The Emotional Traumatization of the Child Victim of Parental Abuse" (Doris J. Harris); (6) "Masochism and Battered Women: Reality or Myth" (Mary Beth Denniston); (7) "Creative Mystique" (John M. Keil); (8) "Sexuality, Childbearing and Family Planning Issues for Physically Challenged Women" (Lucy C. Spruill); (9) "Case Management for Children with Special Needs: A Social Work Frontier for the Late 80's and Beyond" (Ellenjean Morris and Lann E. Thompson); (10) "Pregnant and Parenting Youth" (Pamela Stokes); (11) "Recruiting and Sustaining Adoptive Families for Special Needs Children Through Joint Planning" (Dale Brantley and Emogene Austin); (12) "How a Diagnostic Clinic Helps to Effect the Adoption of Some Children with Special Needs" (Cecilia J. Dwyer); (13) "AIDS: A Public Health and Organizational Crisis" (Lawrence C. Shulman); and (14) "Workshop Summary" (Rhonda R. Brode). (NB)

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PROCEEDINGS

"IMPLEMENTING A FORWARD PLAN:
A PUBLIC HEALTH SOCIAL WORK CHALLENGE"

April 26 - 29, 1987
University Inn
Pittsburgh, PA

SPONSORED BY:

Bureau of Maternal and Child Health
and Resources Development
Health Resources and Services Administration
Public Health Service
Department of Health and Human Services

AND

University of Pittsburgh
Graduate School of Public Health
Department of Health Services Administration
Public Health Social Work Program

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A PUBLIC HEALTH SOCIAL WORK CHALLENGE
April 26 - April 29, 1987

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N.B. Addresses and job titles are those recorded as of April, 1987.

INTRODUCTION

The 1987 Institute held during the University's Bicentennial year, had as its focus the implementation of a "Forward Plan" for Public Health Social Work in Maternal and Child Health. This plan was developed by a group of professionals in our field with the results published during the 1986 golden anniversary of the Maternal and Child Health Program. It is then appropriate, when recognizing anniversaries (200 years for the University, 50 years for Maternal and Child Health) to look back on accomplishments, and to look forward to greater achievements. This, the Institute attempted to do.

The participants were welcomed by Barbara K. Shore, President of the University Faculty Senate and Chair of the Doctoral Program in the School of Social Work. She highlighted the importance of the inter-relationship between public health and social work and how each can utilize and profit from one another's skills. The joint public health-social work program at the University facilitates and enhances this relationship as the joint students pursue their educational program.

The keynote speaker, Alex Gitterman, one of the conveners of the working group that developed the Forward Plan, summarized the major ideas in the Plan and concluded with some thoughts on Prevention and the implications this had for Public Health Social Work.

The luncheon speaker on the first day was John M. Keil, a creative advertising executive of national renown, who delighted his audience with his presentation. Not only was he highly entertaining, but his message on how the profession can best sell itself as well received and seen as a goal to be achieved.

Tuesday morning's speaker, Lucy Spruill, discussed service delivery issues in the areas of sexuality, childbearing, and family planning from the perspective of physically challenged women who are the recipients of services in these areas, suggesting that professionals draw upon the natural creativity and problem-solving abilities of patients with disabilities in approaching maternal and child health problems.

Lawrence C. Shulman was Tuesday's luncheon speaker, bringing a somber note to the group when he vividly detailed his experience with patients on a daily basis as a social work executive of a large Metropolitan with a five year experience in treating patients with Acquired Immunodeficiency Syndrome (AIDS). He detailed the tremendous costs in treating patients with this condition, both financial and emotional. The

implications for social work professionals were made very clear, with the necessity of a coordinated approach to policy, planning and financing so as to prevent the fragmentation of services and the burden of care from falling on any one organization or sector of society.

Workshops covering eight different topics were presented during two days of the Institute, with four being presented twice on the first day, and the other four twice also on the second day, thus giving participants an opportunity for exposure to four topic areas.

Where available, the papers outlining the content of the workshops are presented in these proceedings. As was the intention, attendance at these sessions continued the opportunity for participants to further develop their public health social work skills, and to learn about current activities and interventions in these problem areas.

Wednesday morning, Rhonda R. Brode presented a clear and succinct summarization of the Institute. She highlighted the presentations of the speakers, and synthesized the key points of the eight workshops, monumental tasks expertly done.

Our thanks to the Planning Committee for its invaluable contribution to the Institute format, to the speakers and workshop leaders and recorders, to the summarizer and to the participants for their interest and support.

For assistance with arrangements, registration and compilation of the Proceedings, thanks to Barbara Montgomery, Tina Herbst, and Catherine Orris.

And for her continued support, sponsorhip and encouragement, our deepest gratitude to Juanita Evans.

Gerald C. St. Denis

PROGRAM

1987 PUBLIC HEALTH SOCIAL WORK INSTITUTE

IMPLEMENTING A FORWARD PLAN:
A PUBLIC HEALTH SOCIAL WORK CHALLENGE

April 26 - April 29, 1987
University Inn
Pittsburgh, Pennsylvania

SUNDAY, April 26, 1987

4:00 - 6:00 p.m.	REGISTRATION	Lobby
6:00 p.m.	INFORMAL RECEPTION AND SOCIAL HOUR	Conference Room 4

MONDAY, April 27

8:00 - 9:00 a.m.	REGISTRATION	Lobby
9:00 - 9:15 a.m.	INSTITUTE OVERVIEW Gerald C. St. Denis, Ph.D., M.P.H. Associate Professor and Director Public Health Social Work Program University of Pittsburgh	Oakland West
9:15 - 9:30 a.m.	WELCOME FROM THE UNIVERSITY Barbara K. Shore, Ph.D. President, University Faculty Senate and Chair, Doctoral Program, School of Social Work	
9:30 - 10:15 a.m.	KEYNOTE ADDRESS "PUBLIC HEALTH SOCIAL WORK IN MATERNAL AND CHILD HEALTH: A FORWARD PLAN" Alex Gitterman, Ed.D. Professor, Columbia University, School of Social Work	
10:15 - 10:30 a.m.	BREAK	
10:30 - 12:00	WORKSHOPS*	

*Coffee available in Workshop Rooms.

Monday, April 27 (con't)

	I. FOLLOW-UP OF HIGH RISK INFANTS AND THEIR FAMILIES-- ARE THEY GETTING THE SERVICES THEY NEED? Lynda Mulhauser, M.S.W., Leader Children's National Medical Center Washington, DC Claire Rudolph, Ph.D. Syracuse University, School of Social Work Co-Leaders Ellen Hutchins, M.S.W., Recorder Social Work Consultant Maternal and Infant Health Branch Division of MCH, Dept. of HHS	Conference Room 3
	II. HOMELESS FAMILIES CHILDREN & YOUTH: ADDRESS UNKNOWN Rita Webb, M.S. Children's National Medical Center Washington, DC Dorothy Boyer, M.S.W. PHSW Trainee, Recorder	Conference Room 4
	III. FAMILY VIOLENCE Doris Harris, M.S.W. "THE EMOTIONAL TRAUMATIZATION OF THE CHILD VICTIM OF PARENTAL ABUSE" Mary Beth Denniston, M.S.W. "MASOCHISM AND BATTERED WOMEN: REALITY OR MYTH" Both of Queensboro Society for the Prevention of Cruelty to Children Carol Delany, M.S.W., Recorder Social Work Consultant Primary Care Dept. HHS, Rockville, MD	Conference Room 5
	IV. MIGRANT HEALTH Maria Lago, M.S.W. Social Work Consultant Migrant Health, Dept. of HHS	Annex
12:15 - 2:00	LUNCH John M. Keil - DFS Dorlan Co., New York "CREATIVE MYSTIQUE"	Oakland East
2:00 - 4:30	WORKSHOPS I, II, III, and IV repeated.	

TUESDAY, April 28

9:00	"SEXUALITY, CHILDBEARING AND FAMILY PLANNING ISSUES FOR PHYSICALLY CHALLENGED WOMEN" Lucy Spruill, MSW, MCHS Social Work Administrator Allegheny County Health Dept.	Oakland West
10:00 - 12:00	WORKSHOPS	
	V. "CASE MANAGEMENT FOR CHILDREN WITH SPECIAL HEALTH NEEDS: A SOCIAL WORK FRONTIER FOR THE LATE 80's AND BEYOND" Ellenjean Morris, M.S.W. Social Work Consultant Colorado Dept. of Health Lann E. Thompson, Ed.D, UAF University of Indiana Co-Leaders	Conference Room 3
	VI. PREGNANT & PARENTING YOUTH Pamela Stokes, M.S.S.W., Leader Miami Valley Hospital Dayton Ohio Therthenia W. Lewis, M.S.W. PHSW Trainee, Recorder	Conference Room 4
	VII. SUBSTANCE USE & ABUSE Thomas Anderson, M.S.W. PHSW Trainee Shirley Haberman, University Student Health Services Co-Leaders	Conference Room 5
	VIII. "SPECIAL NEEDS - SPECIAL APPROACHES' GETTING CHILDREN TOGETHER WITH ADOPTIVE PARENTS" Dale Brantley, M.S.S.W., Director Social Services UAF, University of Alabama Cecilia Dwyer, M.S.W., M.Ed. Director of Social Work UAF, University of Cincinnati Co-Leaders	Annex
12:15 - 2:00	LUNCH Lawrence C. Shulman, M.S.W. VP for Social Work Services, St. Luke's/Roosevelt Hospital New York	Oakland East

Tuesday, April 28 (con't)

"AIDS: A PUBLIC HEALTH AND ORGANIZATIONAL CRISIS"
INTRODUCTION: Richard Schulman, M.S.W.
Social Work Program Specialist (AIDS)
Department of HHS

2:00 - 4:30 WORKSHOPS V, VI, VII, and VIII repeated.

6:00 - 10:00 [CAPTAIN'S DINNER CRUISE ON THE THREE RIVERS]

WEDNESDAY, April 29

9:00 - 10:00 Rhonda Brode, M.S.W. Oakland East
Director, Resources Development
Montgomery County (Ohio)
Children's Services
WORKSHOP SUMMARY

NEWS FROM THE FIELD
Participants

10:00 - 11:30 BRUNCH
Juanita Evans, M.S.W., L.C.S.W.
Chief, Public Health Social Work
BHCDA, Division of MCH,
Department of HHS
UPDATE & CLOSING REMARKS

Greetings

By: Barbara K. Shore, Ph.D., A.C.S.W., M.S.(Hyg.)

I am pleased to be here today and add my greetings to those of the other speakers and guests who are present. It is always a great pleasure for me to be part of these important conferences that are held each year because the Joint program between the Graduate School of Public Health and the School of Social Work is so exceedingly important for the doctoral students in our program. This is one of the programs that is most highly valued by our faculty and students. The importance of the inter-relationship between public health and social work is underscored by the excellent teaching and guidance the students receive from Dr. St. Denis, coordinator of this program and the other faculty at the School of Public Health, as well as in the collaborative work that occurs in the Graduate School of Public Health, as well as in the collaborative work that occurs between the Graduate School of Public Health and the School of Social Work. It is therefore always our great pleasure to be part of any of the activities that relate to the joint program. I am also particularly pleased and honored to welcome Juanita Evans, our contact person in Washington, who has supported this program over many years and has had such an extremely critical hand in its success. Without the support she has provided, this program could not have continued at the successful levels at which it has operated for these many years.

There are some important considerations in looking at the collaboration between Social Work and Public Health, particularly in regard to a future orientation. It was very clear that the skills and the research emphasis of public health is extremely relevant to social work. The importance of being able to look at the epidemiology of social, mental, as well as physical disorders and to plan for appropriate intervention at a societal level, cannot be sufficiently emphasized. Social work has an important contribution to offer to public health, in its humanizing of the environment and public health in turn, has strong tools and analytic approaches that are extremely valuable in order to enhance the effectiveness of social work. As I look at the future it become clear that we must indeed be able to apply these tools to a variety of our activities, including looking at social problems with a good solid public health eye. It is further critical that we recognize the importance continually of thinking "prevention".

We have much to learn in this regard from the work that public health does. As we look at the multiple causation of problems and at the importance of chronic illness in our society today, it becomes clear that the tools of public health and the

approaches used are extremely additive to the effectiveness of social work. Conversely, social work does have the benefit of bridging the linkage between the individual and the society, in looking at the interface between individuals and society.

As our students progress through the public health and social work program, they are able to enhance their range of research skills and their knowledge of analytic skills. It is certainly the look of the future that workers in the human services must be able to bridge the linkages between the individual and the society within which the individual is functioning, in order to be able to be effective in planning for the future the quality of life for all of the varied population of our country. This interface is especially vital when we acknowledge that the maternal and child health vision that supports this program is probably at the cutting edge of preventive work and therefore has a most important mission that we not only respect and support, but are delighted to be able to offer to our students for the expansion of their knowledge and ability. Our relationship enables our students to emerge from this program as effective policy makers, teachers, researchers, administrators and extremely high level practitioners.

Once more, it is always a pleasure to be here. We hope our program will go from strength to strength for the many years ahead and we appreciate so much the opportunity always to share with our colleagues in public health the important work of helping our students, as well as ourselves, to constantly broaden our horizons.

SOCIAL WORK LOOKS FORWARD

Alex Gitterman, Ed.D.

I appreciate the invitation and the opportunity to discuss the contents of the monograph, Public Health Social Work in Maternal and Child Health: A Forward Plan. Professor St. Denis assured me that the "majority of the audience will not have seen or read the Plan." I have reacted to this assurance with some ambivalence: on the one hand, relieved that I will be presenting new material rather than boringly repeat what you have already read; on the other hand, quite anxious about your not having seen it because that raises issues about how we distributed the document. My preference, therefore, would be that you had received the report, admired its beautiful cover, but had not had the opportunity to examine its contents. Based upon this latter assumption, I will attempt to summarize the major ideas in the Plan and then conclude with some thoughts about prevention and its implications for public health social work.

The United States Department of Health and Human Resources, Public Health Service, Health Resources and Services Administration published a draft of a Forward Plan for the Division of Maternal and Child Health (DMCH) for the years 1984-1989.(1) This Forward Plan was produced for the administrative reference use of staff involved at all levels of government in the administration and implementation of the MCH Services Block Grant Program. The Forward Plan attempted to 1) provide a comprehensive framework to serve as a rational basis for decisions and recommendations made as part of the annual Federal budgetary and legislative process, 2) outline the view of the Federal MCH Agency about major problems, issues and priorities in maternal and child health and 3) further clarify goals, priorities and future directions of health services for mothers and children as a basis for program planning and improvement at all levels of government.

The Columbia University School of Social Work was honored by its selection to plan a working conference for the purpose of developing greater conceptual clarity and establishing priorities for social work within the context of the Forward Plan. A Program Planning Advisory Committee was convened in Bethesda, Maryland, November 7th to 9th, 1984, to develop the focus and format for determining the long-term goal of designing the social work participation in meeting the challenge of the Forward Plan. The Committee identified major issues and topic areas, recommended that a working conference be convened and suggested speakers and conference participants. A smaller

committee at the Columbia University School of Social Work assisted in establishing and implementing the final plan for the working conference, which was held at the Linden Hill Hotel and Racquet Club in Bethesda, Maryland, from June 23 through June 26, 1985.

Conference Overview

The sixty invited participants at the conference represented social workers in direct practice, supervision and administration in hospitals and public health settings, faculty in schools of social work and public health, as well as federal representatives, all with a special interest in maternal and child health. The format included formal presentations, respondents and workshop deliberations focused on assigned topics. Reports from the workshop were built into the program. The conference overview was begun with introductory remarks by Vince L. Hutchins, M.D., Director of the Division of Maternal and Child Health.(2) Juanita Evans, chief social worker of the Bureau of Health Care Delivery and Assistance (BHCDA) followed with a "Mission" statement which also presented the Working Conference with its charge, i.e., its purpose, focus and direction.(3) Elizabeth L. Watkins, D.Sc. Professor, Department of Maternal and Child Health, School of Public Health, University of North Carolina at Chapel Hill, presented the keynote address, "The Conceptual Base for Public Health Social Work" which highlighted the historial base for social work's strong involvement in maternal and child health with its movement toward more comprehensiveness in its approach and more sophistication in its professional practice, with ever growing concerns with epidemiology and prevention.(4) She emphasized the current and future characteristics of public health social work, promoting the increasing need for public health social workers with administrative skills, sophistication in program planning and evaluation and leadership in advocating for legislative and social change.

Dr. William T. Hall, Professor Emeritus, Graduate School of Public Health, University of Pittsburgh, respondent to Dr. Watkins' paper, supported the need to help social workers develop a "public health perspective" but also alerted the participants to take into account the realities of the world of work in framing recommendations.(5)

Background Papers and Working Recommendations

C. Jean Morton, Associate Dean for Student Affairs, School of Public Health, University of California, Berkeley, examined issues and recommendations in setting priorities for public health social work in relation to four population groups: mothers and infants, children, adolescents and the chronically

ill and physically handicapped child.(6) She and her respondent, Alicia L. Fairley, Executive Assistant to the Commissioner, Commission of Public Health, Washington, D.C., agreed on the issues and priorities for public health social work, suggesting that emphasis be placed on access to perinatal care, on the psychosocial components of perinatal care and on policy changes in Medicaid and Income Support programs for mothers and infants; in child health on access to health on strengthening adolescent health services for particular populations and on the prevention of adolescent pregnancy; and in chronically ill and physically handicapped children on reaffirming the family as a partner in the provision of care. Collectively the priorities focused on access to services, the family and the relationship between poverty and health status. They are oriented toward prevention, population groups and interdisciplinary approaches. Alicia Fairley also promoted a greater involvement in, and more leadership by social workers, in the "New Morbidities" of substance abuse, neglect, violence and learning disabilities.(7) In relation to the chronically ill and handicapped child, she urged the development of a uniform definition of high risk, indentification and management of the zero to three year old and development of a data base.

In each of the four workshop sessions addressing the needs of the four specific population groups (mothers and infants, children, adolescents, and the chronically ill and physically handicapped child),(8) there was support of the recommendations made by the speaker and respondent. In addition, the Mothers and Infants group emphasized the need for social workers to develop data, disseminate information and influence public policy based on the knowledge they receive from serving this population. In providing direct services, social workers needed to help to overcome social, psychological, cultural, and economic barriers to access and utilization of care. They also urged social workers to take the lead in coalition building, policy setting, research and program administration to determine solutions for economic disparities that impact negatively on the health status of mothers and children.

The workshop group examining issues related to children and their families emphasized the need for programs to broaden their approaches by stressing primary prevention and early intervention. They indicated that public health social workers should become more active in researching child health issues, in standardizing practice effectiveness measures to be utilized in program evaluation and in planning programs which enhance the role and function of families from a diverse range of ethnic groups. The workshop dealing with issues related to the adolescent, calling for alternative, non-traditional service delivery models and programs which are multi-focused, have a preventive emphasis and are geared to reaching and serving the risk-taking and violent behavior group, the homeless youths, and

the chronically ill and handicapped adolescent. They also highlighted the need for education programs for youths which are relevant to the labor market, the need for inclusion of adolescents on advisory boards and planning committees, the need for research to evaluate programs and the establishment of training programs geared to prospective parents and to community understanding of the needs of adolescents. They especially called for commitment of federal, state and local agencies to the development and financing of multidisciplinary adolescent health programs, with sufficient time allocated for viable programs to test their effectiveness. The workshop group addressing issues affecting the chronically ill and physically handicapped child recognized the insufficiency of existing data and stressed the need for data collection incorporating psychosocial needs. They urged social workers to intensify outreach and case-finding efforts, to give priority to the development of tools to evaluate the psychosocial needs of these children and their families, and to promote programs which have a life cycle perspective and focus on coordination of the multiple services this population requires. All of the workshops discussing the specific population groups emphasized the need to insure access to care by addressing the barriers to utilization of health care programs. They all stressed the need for an increase in the employment of public health social workers at the service delivery and planning levels to address the psychosocial needs and to insure their incorporation in program planning. All also identified expanded program needs related to their specific populations and supported the needs identified in the Forward Plan.

In the second substantive area, Standards for Public Health Social Work, Ernestine Player, Director, Office of Public Health Social Work, South Carolina Department of Health and Environmental Control, proposed standards for public health social work practice, Roger White, Dr. P.H., John Hopkins School of Hygiene and Public Health, Department of Maternal and Child Health, discussed measuring the standards and Lawrence Shulman, Vice President for Social Work Services, St. Lukes/Roosevelt Hospital, responded to their respective papers. Ms. Player stressed the need for written standards, policies and procedures manuals for all departments of social work, with standards focused toward the public health model of practice.(9) She identified the following as areas to be incorporated in the development of standards: 1) the educational preparation of the person responsible for the direction of social work in an agency and/or for the written state and district social work program plans; 2) the social work goals and objectives; 3) the function of the public health social work staff; 4) the research responsibility of staff; 5) staffing and productivity expectations; 6) performance appraisal or quality assurance assessment; and 7) responsibility relative to student and staff training. She also stressed the importance of data to account for our services to our own profession and to health planners.

Dr. White pointed out that the measurement of public health social work requires the establishment of standards in measurable terms.(10) Measuring standards for public health social work experience qualifications, however, have been hampered because of lack of consensus in defining public health social work practice and because of the lack of explicit training in schools of social work in the tools of public health social work. He emphasized that there are three categories of independent variables which may be used in measuring the degree to which program goals are achieved: 1) as predisposing variables (including socio-demographic, previous behavior, experience, attitudes), 2) enabling variables, facilitating or barrier factors, factors external to individuals, the availability of resources), and 3) need variables (health status, measurement of impairment or disability). Dependent variables are the outcome measures based upon program goals.

Shulman confirmed that the core/generic structural standards developed by NASW, APHA Social Workers and others could serve as a base for public health social workers in maternal and child health to build on. The document can be used to actively support social work as a core profession within the structure of health care.(11) He directed the group to go beyond the structural standards to interpret, demonstrate and validate what we do and to legitimize the standards through practice and research. His recommendations included the involvement of major social work organizations in defining and developing outcome measures and their resulting standards, and in pooling resources to develop effective staffing and workload standards.

The three workshops which followed these presentations enunciated recommendations for public health social work practice standards on the Federal, State, and Local levels.(12) They identified the training, funding and staffing factors adversely affecting the addressing of social issues impacting on the health of the nation. The Federal level workshop group emphasized the need for a classification system identifying the major categories of psychosocial problems, encouragement and support of research applications from social workers, support of joint training programs for social workers in schools of social work and public health and the development of materials providing a conceptual model for public health social work. The State level workshops called on states to take greater responsibility for developing plans for public health social work, using NASW standards as a model. Social workers at the state level were urged to engage in research activities, collaborate with other state public health social workers to identify measures which deal with prevention of the psychosocial problems affecting health status, develop staffing/population ratios, etc. They called on the Federal level to identify the psychosocial risk factors for individuals and communities, and called for a minimum educational level of a masters degree in

social work with additional clinical and administrative experience for state level public health social work staff. They emphasized that each State should have an administrative public health social worker to plan and manage public health social work activities and to provide leadership for reaching target populations. Finally, the Local level workshop recommended that public health social work be integral at the delivery level in all public health programs.

The third major substantive area focused on knowledge and skill required for social work practice in maternal and child health. Kaz Kumabe, DSW, Professor of Social Work and Maternal and Child Health, University of Hawaii School of Social Work and School of Public Health, reminded the participants that the Federal MCH Guidelines delineated the knowledge and skill requirements for public health social work in leadership positions e.g. in program development, policy formulation, and in administrative and leadership skills.(13) The MCH staff social worker, in addition to clinical knowledge and skills, requires administrative, consultant and programming knowledge and skill. She identified nine basic knowledge and skill requirements and added the following specific areas in which public health social workers require special knowledge and skill: integrative skills; conceptual frameworks and concepts; cultural values and health care; administration and management; networking, research and epidemiology.

In responding, Alma T. Young, Ed.D., Associate Director, Department of Social Work Services, Mt. Sinai Hospital, supported Kumabe's delineation of knowledge and skill requirements.(14) She alerted us to the ethical dilemmas MCH social workers face today and their need for support in this area. As Kumabe, she stressed that continuous learning is fundamental to our professional development and must include: sharpening of assessment skills; use of various treatment modalities; improving collaboration and communication skills; innovations in program planning and techniques for evaluating outcomes.

The two workshop sessions which followed focused on knowledge and skill issues in the practice setting and in the field training setting.(15) They both endorsed the knowledge and skill proposals of the speaker and respondent and stressed the importance of schools of social work and public health collaborating in the training of social work students and staff. The Practice Setting group stressed the need for continuing education and in-service training programs emphasizing public health concepts, program development, research and education methods and interdisciplinary collaborative skills. They highlighted the importance of licensure for social workers.

The field training group emphasized the need for school of social work faculty and field instructors to be given

consultation and training in public health concepts and methods. They suggested that schools of social work and public health develop public health social work training materials, and computerized resources for the field. They also recommended stipends be provided to encourage students to select public health social work as a career.

In the final area, collaboration between schools of social work and public health, Rita Beck Black, DSW, Assistant Professor of Social Work, surveyed the health, public health and child health content in graduate social work and continuing education programs.(16) She noted that while there had been considerable growth in coverage of health content in schools of social work since 1975, approximately one help of the schools did not offer a specific concentration in health. Of greater concern, is the apparent lack of widespread coverage of general public health concepts and skills and specific content in maternal and child health. Issues of curriculum expansion limitations and the lack of viable job opportunities for social workers in public health were raised as obstacles to expanding the public health content for graduate and continuing education social work programs.

Gerald C. St. Denis, Ph.D. Associate Professor and Director, Public Health Social Work Training, Graduate School of Public Health, University of Pittsburgh, presented the sequential model of training in social work and public health (17) and Rosalind S. Miller, Professor, School of Social Work, Columbia University, presented Columbia University's "joint degree model."(18) Time does not permit a summary of these excellent programs. Robert O. Washington, Ph.D. Dean, University of Illinois, Urbana-Champaign, School of Social Work, in response to the presenters, examined various issues related to collaboration, structures and processes.(19)

The three workshop sessions which followed focused on issues of Staff Development, Student Training and Curricula for Schools of Social Work.(20) All of the groups called for collaboration between schools of social work and public health in responding to the education and training needs of students in schools of social work and public health, and for staff in public health or health settings, in gaining needed knowledge and skills in public health and social work concepts and methods.

The workshop on staff development stressed the need for training modules in areas of prevention, epidemiological methods, skills in interdisciplinary collaboration, program and policy development and research. They also recommended that consultation be made available to health settings in many areas, one of which was on research methods and specific research programs. The student training workshop placed primary emphasis on joint programming, academic credit exchanges and joint

academic appointments between public health and social work schools. They recommended that means of overcoming institutional barriers against collaboration and educational sharing between and within university schools and departments be addressed. They also called for relevant health content, greater faculty expertise and faculty awareness of important public health concepts and knowledge base. The workshop on curriculum content recognized the need for incorporating public health concepts and skills into the school of social work curriculum and looked to the Council on Social Work Education, the Division of Maternal and Child Health and the schools of public health and social work to assume a share of the responsibility in promoting the necessary content. In addition, it was recommended that schools of social work utilize field instructors and other social workers with public health expertise as guest lecturers.

The working conference succeeded in its initial goal of gathering a group of highly knowledgeable and skilled social work and public health leaders to work on developing priorities for social work in maternal and child health. The commitment of conference participants to the development of more effective programs geared to promoting the physical, social and emotional health of mothers and children was demonstrated by their willingness to work on the issues at hand. A report of the working conference was produced under the title of Public Health Social Work in Maternal and Child Health: A Forward Plan, which has been widely distributed. The response to the monograph has been overwhelming, with praise expressed for its usefulness in providing an initial step on the road toward the development of a "Forward Plan for Social Work." We have begun a conversation and I am pleased that it is continuing.

Conclusion

In the spirit of continuing this conversation, I would like to conclude with some comments about prevention and its potential implications for public health social work. The primary objective of prevention is to forestall and anticipate some undesirable event or condition which might otherwise take place and spread. As you know, primary prevention has two aspects: 1) specific protection - that is an explicit producure for disease prevention in which a population at risk is identified and something is done to it to strengthen its resistance; 2) health promotion - that is an emphasis upon improving the quality of life and raising the general health level of a population. Social workers have inherited from our settlement house pioneers a third prevention strategy, 3) environmental change - that is, doing something about the social condition which plays host to and fosters the problems. In

times like the present, this last tradition, if not ignored, is certainly seldom funded. Funding and consequently professional interests, are both primarily engaged in the "specific protection" aspect of prevention.

I am apprehensive about this direction. My primary concern is that by emphasizing "specific protection," we may be promising more than we can deliver. By seeking and accepting restrictively defined prevention funding, we put ourselves in a position of promising to reduce or eliminate such problems as child abuse, mental illness, drug addiction, teenage pregnancy, etc. And when our efforts fail, as they inevitably do, we diminish our professional credibility and increase the burdens of the populations we seek to serve.

We fail because our work is with the most oppressed populations. Childhood poverty, for example, is engrained in our society.

> "In 1984, more than 1/5 of America's 62 million children under 18 lived in poverty: nearly one of every two black children, two of every five hispanic children, and one of every six white children, fall at/or below the poverty level ... Today our youngest children, those under the age of six, are more likely to be poor than any other group ... (21)

Since 1979, the number of children living in poverty increased by over 30%.(22)

This increase in children living in poverty is most evident in the dramatic increase of homeless families which now constitute approximately 20% of all homeless. In New York City less than one thousand families were idenified as homeless before 1982; in 1985 - 3 years later - it was contrasted to 4,000 families with 8,000 children.(23) Moreover, it has been estimated that between 250,000 and 500,000 youth are homeless nationwide.(24)

The consequences of childhood poverty are many. Poor children are more likely than others to suffer from various acute illnesses and specific health problems. At every age, poor children face a higher risk of death.(25) They are more likely to be exposed to violence, malnutrition, poor education, family disruption, parental institutionalization or incarceration, and consequently, more likely than other children to respond with antisocial behavior, lethargy and depression.

Childhood poverty is deeply and disgracefully embedded in our society. The high level of unemployment, decrease in public entitlements, inflation, increase in adolescent pregnancy and out-of-wedlock births all conspire to aggregate the dimensions

of childhood poverty, and without a social and moral commitment to the disadvantaged in our society, the problems will become more urgent, desperate and dangerous.

Within this social context, the basic premise of prevention - that is intervening before a problem has "struck" - has to be re-examined. If one identifies poverty as the major problem and it has certainly "struck," prevention of social ills becomes an illusive objective. While "health promotion" strategies are certainly critical interventions, I do have reservation about the usefulness of "specific protection" strategies. The narrowly defined prevention programs to elimate adolescent pregnancy, substance abuse, child abuse, mental illness invite failure because these conditions are much more socio-economic problems rather than they are personality problems. Programs that teach adolescents at "risk" of pregnancy to say "no" or parents at "risk" of child abuse to manage their angry feelings, no matter how useful a service (and they are extremely useful services), do not deal with the multi-dimensional pathways to social problems. In fact, all new immigrant groups have shown high rates of "social pathology." As these groups achieved economic security, the "social pathology" prevalence rates declined. These "social pathologies" are like a high fever: "specific protection" interventions may in some ways act like a premature use of the aspirin - momentarily reduce a fever, but simultaneously disguise the problem. "Social pathologies" are outcomes of complex ecological chains - attributes of the individual's genetic, bio-psycho social make-up, and the structures of the family, social networks, community, school, workplace, religious organization, health system, recreational resources, general culture, sub-culture, social class, and the polity.

Another problem with "specific protection" strategies is difficulty in identifying populations at "risk." Certain "social pathologies," for example, have been associated with pathogenic family processes. Siblings of drug users have been found to be more likely to be at higher risk for drug use and abuse than other children.(26) Similarly, children with one schizophrenic parent have a 7-19% higher risk for psychosis than the risk in the population-at-large, and a 29% risk if both parents are overtly schizophrenic.(27) What do we do with these findings? Do we stigmatize all people with certain group defined characteristics and define them at "risk." To draw a parallel, a colleague was asked to study alcohol abuse in the N.Y.C. Police Department. He found that Irish policemen were at greatest "risk" of alcoholism. What do we do with this finding? Should we recommend that all Irish policemen not be hired? When we move beyond a universal notion of service and identify a sub-population at "risk," we are in danger of adding to their burdens by stigmatizing and even possibly scapegoating them.

One final concern about "specific protection" strategy is the potential for imposing social ideologies and values on problem definitions. Bleuler, for example, is quoted to have stated the following in relation to preventing schizophrenia:

> The avoidance of masturbation, of disappointments in love, of strains or fights, are recommendations which can be made with a clear conscience, because these are things to be avoided in all circumstances." (28)

Currently, a debate exists about appropriateness of the distribution of birth control information and devices in the public schools. Some argue it will increase adolescent sexual activity; others argue it will decrease unwanted pregnancies; still others argue that this is a deliberate strategy to decrease minority populations; and still others are against it on religious grounds. Prevalent values can have a powerful impact on how problems are defined and solutions proposed.

A "health promotion" strategy is an alternative. It attempts to improve the quality of life and foster optimal health in the population. It focuses on "wellness" and maintaining health rather than mitigating "sickness" and restoring health. Services based upon a developmental scheme emphasize access to health education, recreation, socialization, and cultural resources, multi-pathways to well being. Examples of such an approach include genetic counseling, marital counseling, pregnancy planning, pre and post natal care, obstetrical care, well baby clinics, pre-school programs and enrichment programs, early school identification, parental involvement in school programs and sex education. These programs attempt to engage social competence, cognitive and emotional coping, and achievement. Maximizing early positive experiences and minimizing negative experiences are more likely to have long lasting effects. Thus, in social planning for universal services, services need to be designed to strengthen major social institutions, the family, the school, the world of work and the community. When these institutions are strengthened, general health becomes promoted.

Along with refining "health promotion" strategies, we need to undertake conversations about the third strategy, "environmental change." If we argue that "specific protection" strategies represent limited solutions, then we have to have conferences that focus on interdisciplinary coalition building which deal with the problems associated with poverty, unemployment, homelessness, discrimination and prejudice. We should have conversations on how we can revitalize the community organization tradition in our profession. Community organizing is essential for both instrumental accomplishments (such as a voter registration drive), but equally important for the experience of challenging the imbalance in power relations.

Participation and action can challenge hopelessness, despair, and apathy. Experiencing and developing a belief that one can take initiative and some control of one's environment, is a powerful strategy for promoting physical as well as mental health. It's time for us to re-discover our roots - I hope we will make a beginning today. Thank you.

NOTES

1. Division of Maternal and Child Health. Forward Plan: Maternal and Child Health: 1984-1989. Washington, DC: Division of Maternal and Child Health, Public Health Service. Department of Health and Human Services, 1984.

2. Vince L. Hutchins, "Celebrating a Partnership: Social Work and Maternal Child Health," in Public Health Social Work in Maternal and Child Health, eds. A. Gitterman, R. Black, F. Stein. New York: Columbia University School of Social Work, 1985, pp. 3-12.

3. Juanita Evans, "Mission. Ibid., pp. 13-16.

4. Elizabeth L. Watkins, "The Conceptual Base for Public Health Social Work," Ibid., pp. 17-34.

5. William T. Hall, "Response," Ibid., pp. 35-37.

6. C. Jean Morton, "Public Health Social Work Priorities in Maternal and Child Health, Ibid., pp. 41-64.

7. Alicia L. Fairley, "Response," Ibid., pp. 65-70.

8. "Workshop Recommendations," Ibid., pp. 71-82.

9. Ernestine Player, "Standards for Public Health Social Work Practice," Ibid., pp. 83-96.

10. Roger B. White, "Measuring Standards for Public Health Social Work Practice," Ibid., pp. 97-102.

11. Lawrence C. Shulman, "Response," Ibid., pp. 103-107.

12. "Workshop Recommendations," Ibid., pp. 109-131.

13. Kax Kumabe, "Knowledge and Skill Requirements for Social Work Practice in Maternal and Child Health," Ibid., pp. 133-148.

14. Alma T. Young, "Response," Ibid., pp. 149-153.

15. "Workshop Recommendations," Ibid., pp. 155-158.

16. Rita Beck Black, "The State of the Art in Public Health Social Work Education: Public Health and Maternal Child Health Content in Graduate and Continuing Education Programs," Ibid., pp. 159-166.

17. Gerald C. St. Denis, "Collaboration Between Schools of Public Health and Social Work: A Sequential Model," Ibid., pp. 167-178.

18. Rosalind S. Miller, "Collaboration Between Schools of Public Health and Social Work: A Joint Degree Model, "Ibid., pp. 179-186.

19. Robert W. Washington, "Response," Ibid., pp. 187-195.

20. "Workshop Recommendations," Ibid., pp. 197-201.

21. Division of Maternal and Child Health, Information Bulletin: Youth 2000. U.S. Department of Health and Human Services, Public Health Services, Health and Resources and Service Administration, Bureau of Health Care Delivery and Assistance, September, 1986, pp. 3-4.

22. National Association of Social Workers, News NASW Letter, Albany, N.Y.: New York State Chapter, NASW, March, 1967, p. 1.

23. The Harvard Medical School, Mental Health Letter, Boston, MA: The Harvard Medical School, January, 1987, p. 5.

24. Ibid., p. 5.

25. Information Bulletin: Youth 2000, op. cit., p. 4.

26. Elizabeth Taylor Vance, "A Typology of Risks and the Disabilities of Low Status, " The Issues: An Overview of Primary Prevention, eds. G. Albee, J. Jaffe. Hanover, New Hampshire: University Press of New England, 1977, pp. 207-37.

27. Ellen Meyer-Kimling, "Issues Pertaining to Prevention and Intervention of Genetic Disorders Affecting Human Behavior," Ibid., pp. 68-91.

28. E. Cumming, "Unresolved Problems of Prevention," Canadian Mental Health, Suppl. 56, 1968, p. 3.

HIGH RISK INFANTS:
ARE WE MEETING THEIR NEEDS?

Lynda C. Mulhauser, M.S.W.

We must sharpen our skills to explore the needs of the high risk infant. One of our main goals is to use the Forward Plan of Public Health Social Work and translate it into workable recommendations for both the public health administrator and the clinician. However, these early interventions for infants and families can only be achieved if we look at the needs of the parents who have given birth to these high risk infants.

Few families are prepared for the shock of having a baby born prematurely or with a birth defect. Some families have described it to me as walking through a minefield--their lives are irrevocably changed. No one knows what to do or say when such an infant is born. In fact, Drotar, in an article in Pediatrics, stated, "it is ironic that our society has no customs, traditions or rites to support parents when they need it the most."(1) After the large majority of healthy babies are born, people send flowers or cigars are passed out; parents of an infant with a disability must, instead, learn a whole new vocabulary of medical terms and try to absorb the enormity of this baby who is often attached to many tubes and placed on a cardiac monitor. Parents, often in shock themselves, also must explain to siblings, grandparents, and friends this new reality in their lives; at the same time, they are often grieving for the healthy baby who did not arrive as planned.

After several days, weeks, or even months in an Intensive Care Nursery, both the infant and the family must make the transition from the tertiary center to the home. Leaving the hospital is a time of high anxiety for many parents. Even though they wished for this moment, the new parents are fearful. After all, their baby has been cared for by three shifts of nurses and medical specialists for 24 hours a day in the hospital. On the day of discharge, it is just the two of them. Unfortunately, it is during this period after discharge that the system often breaks down. We must anticipate with the family, the nursing and medical teams, and the community agencies what will be the main sources of both stress and strength for each family. As an example, can you imagine the difficulties of a homeless family caring for a child on a cardiac monitor. The planning and coordination would be an enormous task. The hospital-based social worker is in an ideal position to pull these multiple systems together with the family. When a social worker has been active with parents during this neonatal period, he or she can perform several tasks: 1) Provide a safe outlet for the parents' fears and

concerns; 2) Enhance past coping strategies of the couple or the parent; 3) Facilitate access to available financial resources such as Supplemental Security Income, Crippled Children's Services, or Medicaid; 4) Be knowledgable about infant stimulation programs in the community; 5) Assure that families are referred to the appropriate services and that they have realistic expectations about what these community programs can provide; and 6) Recognize that families are the central caregivers over the long haul.

These are overwhelming tasks for everyone. The overloaded caseworker may not be able to meet all these needs for the family, but he or she should start building coalitions to get the infant into the right system as soon as possible. All of the above tasks can only be mastered if the social worker has developed a clear family needs assessment. Only by doing so can the clinician adequately determine what the service needs are and where scarce resources should be channeled; then, anticipatory guidance can be given to families so they can be linked with appropriate services and other families before discharge.

Many parents of premature babies have a hard time letting go of feelings of vulnerability and overprotectiveness. They are fearful that they will not be able to save their child, especially if the infant has been on a monitor in the hospital. Drs. Morris Green and Albert Solnit did a classic study of 25 children who had what they called the "Vulnerable Child Syndrome."(2) All the children had at one point in their lives been very sick. Although the children all recovered completely, the parents never got over the trauma of almost losing them. As one mother says, "I don't think I'll ever get over this fatalistic sense that he's frailer than other children, that someday something will happen to him."(3)

To combat these feelings of vulnerability and loss of control, parents should learn, in advance of hospital discharge, who will be working with them and their infant. The fear of caring for such a "fragile" infant can be lessened if families begin to see themselves as the case managers for their babies. The case management function is often shared with or delegated to medical, nursing, or social work personnel in the hospital while parents are still learning about their infant's acute and long-term needs. In fact, if the new parent is a teenager, then extended family members must also participate in this discharge process. However, "social workers can contribute to strengthening families and to empowering them to act in their own behalf throughout the life cycle," according to The Forward Plan.(4)

It is important as well to focus on what we can actually do as advocates for these families. Social workers are often the only link between the family and community systems. Certain

tools of the social work profession can facilitate this transition from hospital to home. The first two of these tools are program-oriented: 1) The Forward Plan of Public Health Social Work, and 2) Public Law 99-457: The Education of the Handicapped Amendments of 1986. The next two tools are more pragmatic for the clinician: 3) Networking and Coalition Building, and 4) The Year One Project.

When we speak about implementing the Forward Plan, there are 215 pages of issues and recommendations for us to consider. The Forward Plan actually highlights the most useful strategies for overcoming obstacles to community-based care. For example, a major recommendation is for public health social workers to be aware of the multiple agencies in their state that provide services to developmentally delayed infants and toddlers. Another goal in this document is to utilize a systems approach for the care of these children; the approach should be family-based and provided by an interdisciplinary team.

According to the Forward Plan, "Children who require medical intensive care services during the newborn period are at a high risk of medical and social handicapping conditions. About 60 percent of all infants born more than eight weeks prematurely have minor or major developmental needs."(5) Many other infants, born to substance abusing mothers have even greater risk for future disabilities.

Today, there are over 260,000 preschool handicapped children who are participating in the educational programs mandated by Public Law 94-142, the Education for All Handicapped Children Act. However, there are still 70,000 preschool handicapped children, ages birth to two years, who need these education programs according to the U.S. Department of Education.(6) For this group of unserved infants and toddlers, social workers will now have access to an important tool-Public Law 99-457; this is a new state grant program that was just passed by Congress on October 8, 1986; it will provide early intervention services for handicapped infants ages birth through two years. For those of us who work in public health and educational programs, the implementation of this new statute will substantially increase our ability to provide services. Furthermore, the law even requires an Individualized Family Service Plan (the IFSP) that recognizes the impact of the infant on the entire family. As Congressman Jeffords stated in the Congressional Record on October 22, 1986, "This bill builds on the strength, the experience and the spirit of Public Law 94-142. All things being equal, each state would be required to serve approximately 26 percent more handicapped preschoolers in five years than they are serving now."(7)

The Department of Education will be proposing detailed regulations to implement PL 99-457. At this point, it looks as if the proposal will be published in the Federal Register this

summer, at which time the agency will ask for public comment. It is imperative that we, as social workers familiarize ourselves with these proposals in order to advocate the right mix of services. Public Law 99-457 will be an excellent mechanism for public health social workers to act now and to build coalitions. Since the law has four years to be implemented, we can begin by ending turf battles and forging interdisciplinary teams; in fact, these teams are mandated in the law. As the first step in the law's building process, the Governor of each state must appoint a "lead agency" to determine the mix of services. Most states have already started this process. For example, in Maryland, the school system is the probable choice; in the District of Columbia, the Public Health Commission; in Virginia, the Mental Health/Mental Retardation Board. All of the above agencies have social workers at either an administrative or direct practice level. In addition, the Governor must establish an "Interagency Coordinating Council" composed of relevant agencies, consumers, and providers. This council will assist in implementing the legislation and identifying resources. Social workers should make sure that they are represented on this council as well.

This is the time to use our knowledge and practice base to strive for timely diagnostic and treatment services. Although Medicaid already pays for some of the services such as physical therapy, the intent of this law is to fill in gaps where they currently exist and to provide services at little or no cost to families. Since we in social work are cognizant of cultural and economic barriers to health care, we should ensure that access problems are tackled under these 1986 Amendments. One example would be to include a provision in the final regulations that each infant receive a workable care plan within one month of leaving the hospital. Certainly we can find other ways to implement timely services. My focus on this law today is for us to use it as a tool to serve these infants and their families.

We do not often have the opportunity to be involved in such a historic undertaking. The first law, 94-142, was enacted in 1975 to provide education to handicapped children in the least restrictive environment. Today, twelve years later, both parents and those of us in community agencies are still actively battling with certain school systems who do not have the manpower or the desire to implement the law.

The next tool is what is generally called the networking function--i.e. building relationships with agencies and caregivers in the community. In each state, either physical therapists or infant stimulation services are sought when an infant leaves the hospital. Yet, we have learned that these care providers often feel inadequate about the multiple medical needs, equipment, and complex medical terminology that these babies require. For example, the Visiting Nurse Association in the Washington, D.C., area solicited the assistance of

Children's Hospital National Medical Center and Georgetown University Hospital, two tertiary centers, for several in-service training sessions.(8) The nurses learned about high-risk infants through didactic courses and a six month practicum of hands-on intervention with these infants. This model also gave the community nurses an overview of typical parent responses during the initial stressful first year. They also learned how to provide anticipatory guidance about developmental needs and how to contact parent support groups. Certainly, this model of linking a tertiary center with a community agency can be duplicated in other communities across the nation to combat the knowledge gap.

The last tool I would like to cite is The Year One Project developed by George Washington University Special Education Department, also in Washington, D.C. This training system is a series of three video tapes to be used individually or together, addressing the specific knowledge needs of care providers for sick, high risk, or handicapped infants in the first year of life. The three modules are: 1) The Hospital Experience, 2) The Family Experience, 3) The Community Experience. Because many sick infants have to return to remote geographic areas, these tapes are an excellent method for getting up-to-date knowledge that might not otherwise be available. For example, The Family Experience videotape highlights the emotional turmoil of families whose infants are at risk for handicaps. The project also provides an accompanying manual for each tape which can be used for further learning. The Community Experience tape shows those infants and their families in need of early community intervention programs and follow up. This tape in particular might be the most useful for this group since one of the target audiences is the community health care provider. It offers realistic models for service and defines medical terminology.

To sum up, public health social workers and nurses now have an additional spectrum of methods and tools to utilize for our clients. Our focus on the transition from hospital to home is critically important. It is the ideal time to mobilize families and agencies to provide early intervention for these high risk infants and their families.

FOOTNOTES

1. Drotar, D., Baskiewicz, A., Irvin, N., et al: The Adaptation To the Birth of an Infant with A Congenital Malformation: Hypothetical Model. Pediatrics 56: 1975: 710.

2. Green, M., and Solnit, A.J.: Reactions to the Threatened Loss of a Child. Pediatrics 34: 1964: 58-66.

3. Robin Henig with Anne Fletcher. Your Premature Baby: New York: Rawson Associates, 1983. p. 196-7.

4. Gitterman, A., Black, R.B., Stein, F., eds. Public Health Social Work in Maternal and Child Health: A Forward Plan. U.S. Department of Health and Human Services, 1985. p. 80.

5. Ibid., p.79.

6. The Congressional Record, 10-22-86. p. H7907

7. Ibid., p. H7906

8. Stiles, K., Lierman, C., and Austin, J.: Training Community Health Nurses in Care of Handicapped Children. The Journal of Continuing Education in Nursing 13(2): 1982: 26-34.

HOMELESS FAMILIES, CHILDREN AND YOUTH: ADDRESS UNKNOWN

Rita A. Webb, M.S.

INTRODUCTION

The plight of the homeless is one which has its roots entrenched in our society for over a number of decades. Historically, the homeless have been viewed as alcoholics, drug addicts and/or transients. Most were described as white males who either wandered the country looking for seasonal spot labor or "hung out" in front of bars, pool halls, or dilapidated hotels. During the mid 50's, with the move towards deinstitutionalization an increasing number of mentally handicapped persons joined the homeless. Still, in the next decade of the 60's, we find the advent of the Flower Children and Hippies. Yet another dimension was added by runaway youth. Finally, with the 70's and 80's, there is a sizeable increase of the number of women, families (children and youth) and minorities who join the ranks of the homeless.

The homeless population emcompasses a diversified group of people who because of a variety of circumstances and reasons have entered into a single category labeled "homeless". Peter Marin, in his essay on "Helping and Hating the Homeless" identifies 10 subgroups within the homeless population:

* Veterans, mainly from the war in Vietnam. In many American cities, vets make up to 50 percent of all homeless males.

* The mentally handicapped. In some parts of the country, roughly a quarter of the homeless would, a couple of decades ago, have been institutionalized.

* The physically disabled or chronically ill, who do not receive any benefits or whose benefits do not enable them to afford permanent shelter.

* The elderly on fixed incomes whose funds are no longer sufficient for their needs.

* Men, women, and whole families pauperized by the loss of a job.

* Single parents, usually women, without the resources or skills to establish new lives.

* Runaway children, many of whom have been abused.

* Alcoholics and those in trouble with drugs (whose troubles often begin with one of the other conditions listed here).

* Immigrants, both legal and illegal, who often are counted among the homeless because they constitute a "problem" in their own right.

* Traditional tramps, hobos, and transients who have taken to the road or the streets for a variety of reasons and who prefer to be there.(1)

From this list of subgroups within the homeless population two things can be extrapolated:

* Many of the homeless, before they were homeless, were people more or less like ourselves: members of the working or middle class.

* The world of the homeless has its roots in various policies, events, and ways of life for which some of us are responsible and from which some of us actually prosper.(2)

For the purposes of this workshop, the focus of the presentation will be on homeless families, with emphasis on the children and youth: a challenge to social workers in public health services.

HOMELESS FAMILIES AND CHILDREN

The burgeoning problem of homeless parents and children is the latest phenomenon to face many of our urban areas. Studies, research, and reports which address the issues of homelessness and its impact upon parents and children are now in progress. Several preliminary reports written by the Child Welfare League of America, the Center for Applied Research and Urban Policy in D.C., and others, place the major reasons of why families enter the homeless population on poverty and lack of affordable housing. For example, over a two year period (1982 to 1984) in New York City alone the numbers of families in shelters almost tripled. Also in New York city it is estimated there are 2,900 families homeless on any given night.(3) In Washington D.C. it is estimated that over 2,000 children are homeless.

When one of the primary identified factors for families becoming homeless is poverty and we begin to look at it in terms of children we find that:

* It is estimated one in every five children in the U.S. lives in poverty.(4)

* 50% of all black children and 40% of all Hispanic children under age 6 are living in poverty.(5)

* Almost 40% of the poor in America are children and 1 in 5 is homeless.(6)

* Nationally, a recent study indicates that 35% of all homeless involves families and children.(7)

A study done by the Child Welfare League found that "for every 10 homeless adults, 8 children were affected". These children were either living with former spouses, current spouses, with relatives or in foster care which represented six times the rate of the general population.(8)

Looking at the broader medical, economical, family and psycho-social factors that impact upon the parents and children we can take the case of L. and her 3 children who were referred to the social worker in a primary pediatric care community health center. The reason for referral was the 7 month old had not had any previous health care, lived in a hotel family shelter, and was in need of prescribed medication for otitis media. L. reported she and her 3 children (ages 7 months, 4 years and 6 years) moved into hotel shelter 6 months ago when she was evicted from her apartment because she was unable to pay the rent. Her income had been from Public Assistance and was $364.00. Her rent had increased over the past few years and was $350.00 plus utilities. Her boyfriend and father of her last child had been out of work for an extended period because of injuries he had sustained from an accident.

She described herself as feeling depressed and overwhelmed by her situation and up until recently, having a total lack of energy. Neither of the two older children had attended school while in shelter and thus her 6 year old son would start school a year late.

Her family support system was minimal in that her 25 year old sister had delivered twins two months previously following a difficult pregnancy, and her 42 year old mother was incarcerated and had delivered a baby during the previous 2 weeks.

The case of L. is but one example of what is being found in homeless families in which there is an increase of poor, single minority female headed families who find themselves on the street. At the city shelter in Washington D.C. where L. resides, officials report a 500% increase in resident utilization of this site. On April 10, 1987 this shelter reported 173 families with 400 children and 183 adults, the majority of the families headed by poor, black, single women, many of whom were pregnant or had just delivered babies.

Financial problems and lack of low cost housing have been identified as key factors in the homelessness of families. Indeed, these are important factors, however, there are other precipitating issues which critically impact these families, but that in trying to help these families, may be minimized or overlooked. These factors/issues include divorce, separation, family conflict, domestic violence, abuse, low paying jobs in

which parent(s) are unable to sustain a home, unemployment, inadequate education, lack of job skills, inferior health care, poor nutrition, etc., etc.

On the other hand, in looking at the parents who find themselves homeless in Washington, D.C. we find as previously mentioned the majority of these families are headed by females. This family constellation is consistent with the overall district's poor urban families in which the majority of the households are headed by single women. The parents often are young with an increasing number who are adolescents. Education levels vary, but often it is found that many of the parents have minimal schooling or job skills.

Many of the mothers are under great distress prior to coming into shelter and continuing throughout the shelter experience. "Homelessness, cramped emergency living quarters, isolation from other family members, friends and neighborhood and uncertainty about the future produce a level of personal stress and despair which often leads to depression. Health risks for all family members increase during periods of homelessness, especially the children who often become victims of neglect or abuse".(9) As an example, take the case of S., a 31 year old woman who has been living in a shelter for battered women with her 3 children who are 11 years, 6 years and 16 months of age. At the time of encounter she had been in the shelter for approximately two months. She had left her husband because he repeatedly physically abused her and the children. S. had left him a year before and stayed in a shelter for several months, but decided to go back to him after she was pressured by family, friends and her children to do so. This time she hoped to never go back.

S. came into contact with the hospital when her 6 year old son was admitted to the inpatient psychiatric unit. She was still living with her abusive husband at the time, and came to family meetings with him on the unit. Soon after her son was discharged from the hospital, S. admitted to her social worker she was afraid that if she disclosed the abusive situation her family was in, she would have her son taken away from her.

The social worker discussed her options with her and her ambivalent feelings about leaving her husband. Once she decided to leave him, it was not so easy to just leave. It was difficult to find a shelter that was not full and would take 3 kids. Finally, soon after a shelter was found, she had to leave it because her husband had abducted the kids from school and demanded that they take him to the shelter. The staff at the shelter called the police, but the family could not stay at the shelter since the husband knew where they were.

Currently the social worker is providing a life line of emotional support to the family. S. reports that she will not go back to her husband despite his letters, calls to the

children's school, etc. urging her to come back. He even tried to get her Public Assistance discontinued by telling officials that he had been supporting her and is still supporting her, and that she should have her benefits cut off.

S. has been committed to bettering her life and has taken steps to do so.

In a study of parents which is entitled "Characteristics of Sheltered Homeless Families", when they looked at the mother's childhood experience they found that:

> A third of the homeless mothers had never known their fathers. More than two-thirds described at least one major family disruption during childhood - almost half were due to separation or divorce of the parents; the rest were due to the death of a parent, mental illness and alcoholism of the parent, abuse resulting in state placement, etc. Less than half of the disruptions occurred when the mother was 5 years old or younger; some of these mothers were often left with one parent, others were placed with a relative, some ended up running away when they got older, several were placed in foster care, and a small number were placed in mental hospitals. One third of the homeless mothers reported that they had been physically abused, generally by their mothers. About 20% of the mothers reported having been sexually abused.(10)

Given some of the mothers' own trauma as children and later life experiences, one can see how these parents as well as their children are victims themselves now placed yet in another vulnerable position that of being homeless.

A case example is Ms. H:

A.H. - patient DOB: 11/02/86

T.H. - mother 18 years old

M.H. - brother 14 months old

D.A. - father 18 years old - involved with visiting, lives with his mother, unemployed

A. - born 36 weeks premature 11/02/86
hospitalized at birth from 11/02/86 through 01/07/87
admitted CHNMC 02/08/87 through 03/08/87 with diagnosis of FTT and r/o apnea - discharged "home"
readmitted to CHNMC 03/18/87 - 04/15/87 with diagnosis of apnea - discharged HSC

1. The initial referral to assess the parenting skills of this 18 year old mother was received 10/19/87

   The findings of this assessment were that although the mother was immature, she was bonded to the child, able to identify a support system of friends and family and appeared to have a permanent address with a telephone available next door.

   The discharge plan of 03/08/87 was as follows:

   1. Referrals to (a) parenting class and (a) home care;

   2. CPR and monitor training for mother and father.

   Approximately 4 days after discharge, the Home Care RN called the hospital social worker to inform her that the address was false and according to neighbors, the mom had not lived there for a year.

2. About 3 days after this phone call, Ms. T.H. contacted the Home Care team to give her current address. She was living in the Pitts Hotel Family Shelter.

   A letter had been sent to the father's address (by hospital social worker) stating that unless the mom contacted either the social worker or the Home Care team a referral would be made to P.S. It is likely the letter precipitated the mom's call to Home Care.

3. The mother and patient were followed in the shelter by the Home Care team until the child was re-admitted on 3.18. Upon admission, it was noted that the child had been appropriately given CPR by the mother when the monitor sounded and subsequently transported to the ER via ambulance.

   Apnea continued to be the diagnosis. The monitor was retained and 30% oxygen added.

   When asked during the 2nd admission why she had given a false address at the time of the first discharge, the mother stated that she knew that the hospital would not have discharged a child to a shelter.

The addition of oxygen during the second admission, meant that the child was unable to return to the Pitts Shelter for the following reasons:

1. The medical staff in the shelter felt concerned about the increased risk of fire.

2. The lack of control over smokers in the shelter.

3. The Home Care Team felt that the mom was not responsible enough to care for a 14 month old son and a baby on a monitor and oxygen.

4. The lack of a positive support system for the mother.

The CH medical staff advised a temporary stay at HSC until either the mom found more permanent housing or the child was weaned from oxygen.

4. The mother refused to sign the child into HSC because she felt the medical staff was against her and would not give her a chance to prove that she could care for her children.

5. The mother continued to display strong and often irrational feelings against HSC placement, often equating placement with taking her child. These feelings persisted in spite of efforts by the hospital staff to explore all possibilities for discharge to the Pitts Shelter and meetings with the medical team to give the mother and staff a chance to talk about the problems with discharge and the child's special needs.

6. After much empathetic support and confrontation, the mother revealed the following history:

She was also premature at birth and feels that the attention she required caused her mother and father to fight constantly, leading to their separation. After the separation Ms. T's mother lived at a variety of temporary addresses until T. was 7 months old and sick enough to require hospitalization. A referral to P.S. was made and custody of T. was taken over by the Protective Services. Subsequently, T's mother shot herself.

The above story was told with phrases like "I killed my mother" and "I am my mother".

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The focus of social work intervention was to show T. what control she had as A.'s mother and what choices she could make.

Ultimately, T. volunteered to sign admission papers to HSC. Currently, mom and her 14 month old son are in the second phase shelter housing, Community of Hope. The social worker at Community of Hope cannot promise that a child on oxygen will be acceptable in their housing; however, she agreed to assess how well T. and son M. adapt to their housing and if all goes well, will consider allowing the baby in with oxygen and monitor.

Issues

1. Extended hospitalization while working with psycho-social issues.

2. Inability of mom to trust.

3. Negative support given by other shelter mothers.

4. Frequent hospitalizations interfering with bonding (as the hospitalizations get more frequent and longer, mom came less often).

   One of T.'s comments was that we didn't know if she was a good mom because she hadn't had the baby home long enough to prove it.

   Literature documents that mothers of FTT children often separate from their children after about 3 months.

5. Concrete problems such as getting transportation to hospital from shelter (hospital social worker often has to provide). Lack of consistent day care for siblings of such children who are in family shelters.

6. Importance of coordination with community resources - Shelter to Hospital to Home Care to P.A. etc.

WHAT CAN WE DO ABOUT HOMELESSNESS?

Families who enter into a homeless shelter situation often may have had some form of a pre-homeless stress related experience, such as the threat of eviction, doubling up with relatives and friends, family conflict and violence. It is felt

that there are preventive measures of a multi-service model that can be utilized to curtail or even prevent the rapid growth of homelessness in our nation.

One such model is the one proposed by Nancy Kaufman in "A Comprehensive Policy Approach to Homelessness".(11)

In this model by Ms. Kaufman a key person is identified as the case manager. This case manager is seen as the glue which holds the continuum of services together. Without it, a person could easily fall back into the homeless cycle. The role of case manager is a natural place for social work services to come into play. The assessment skills, needed for appropriate intervention, and advocacy are inherent to social work profession.

The model Ms. Kaufman designed identifies the various levels or phases of homelessness and the services needed in each phase. She uses a three phase approach in which she moves the homeless from crises to transition and finally stabilization. Along with the phases of homelessness and strong case management, various services are identified. These multi service needs include a number of psycho-social services such as housing, financial, employment, health and social services.

It is clear there are no simple answers in solving the problem of homelessness. However, in order to address this issue there needs to be financial support, policies, community, state, national involvement and well oraganized planned services and approaches which do not compromise the dignity and well-being of the homeless.

REFERENCES

1. Marin, P. "Helping and Hating the Homeless" Harper's Magazine, 1-87 Essay p. 40.

2. Ibid., p. 41.

3. U.S. Conference of Mayors, "The Growth of Hunger, Homelessness and Poverty in America's Cities in 1985: A 25 City Survey". Washington, D.C. January, 1986.

4. U.S. House of Representative, Select Committee on Children Youth and Families, "Report on Poverty and Progress", April 18, 1987.

5. Ibid

6. Ibid

7. Waxman, Laura De Koven and Reyes, Lilia M., "The Growth of Hunger, Homeless and Poverty in America's Cities in 1985: A 25-City Survey, "United States Conference on Mayors, Washington, D.C., January, 1986.

8. Study of Homeless Children and Families Preliminary Findings by Penelope L. Maza, Ph.D., Director of Research, Child Welfare League of America and Judy A. Hall, Ph.D., ACSW, Executive Director, Travelers Aid International.

9. Ruth Harley, Director, Children's Hospital National Medical, Comprehensive Health Care Program, 1986.

10. Bassuk, E., Rubin, L., Lauriat, A. "Characteristics of Sheltered Homeless Families "American Journal of Public Health" 9-86, Vol. 76., No. 9, p. 1097-1100.

11. Kaufman, N.K. Homelessness: A Comprehensive Policy Approach. The Urban and Social Change Review. Vol. 17, No. 1, Winter '84. pp. 22-26.

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THE EMOTIONAL TRAUMATIZATION OF THE CHILD VICTIM OF PARENTAL ABUSE

Doris J. Harris, M.S.W., A.C.S.W., C.S.W.

Our topic today, Family Violence normally evokes visions of physical assault resulting in some form of bodily harm being perpetrated on the victim. I would like us to consider another framework dealing with emotional trauma as a form of violence perpetrated by the parent toward the child. Webster's Dictionary includes the following among its definitions of violence: "injury by or as if by distortion; infringement, or profanity; an intense turbulent, or furious and often destructive action or force." Battering of a psychological nature includes verbal abuse, severe neglect through acts of omission or commission, abandonment, failure to provide basic necessities or medical care, failure to provide nurturance or stimulation; and in the case of sexual abuse, a violation of trust with an assault on the psyche. Battering of a physical nature includes the infliction on the child of physical injury by other than accidental means which could likely cause death or disfigurement or loss of any bodily function.

Graham has shown that in a survey of normal mothers interviewed one month after the birth of their children, 61 percent admitted that there had been times when they felt angry with their babies and 81 percent felt that the experience of having a baby to cope with had made them more sympathetic to baby batterers.(1) Looking at this "normal" phenomenon on a scale from 0-10 we can see that it is just a matter of degree as to when the reaction pattern becomes abnormal with the impulse towards violence taking control.

In order to understand how this happens in regard to parent-child interaction, we need to start at the beginning and examine the evolution of the child's normal pattern of development, the resulting life cycle and its relationships as that child becomes as adult, starts a family and the cycle continues with its repetition of learned adjustment patterns.

Erickson's Stages of the Life Cycle provides us with a good vehicle for examining the various developmental stages from infancy through adolescence. In Stage I, birth to age 2 involves the development of a capacity to trust or mistrust. Parents who provide consistent care for the infant, including affection and emotional security, as well as meeting basic physical needs, help the infant to develop a sense of trust in himself and an ability to trust other people. On the other hand, inconsistent, inadequate, or rejecting care may prevent the infant from developing the capacity to hope.

Stage II covers roughly the second and third years of life. How parents handle such matters as toilet training and the toddler's capacity for exploring the environment will strongly influence whether the child is likely to develop a favorable balance between senses of autonomy and shame. A harshly restrictive or compulsive parent may endanger a child who is overwhelmed with shame and doubt, which may develop into a life-long sense of basic insecurity.

The Third Stage, age 3-5, is critical of initiative, which adds to autonomy an element of undertaking, planning, ever "attacking" a new task for the sake of being active. The danger of this stage, according to Erickson, is the risk that the child will develop an excessive sense of guilt over actions initiated in enjoyment of his new locomotion or mental capacities.

In the Fourth Stage, age 6-11, the child learns the pleasure of productive work, of completing a project through sustained effort. The danger of this stage is that the child will develop a sense of inadequacy and inferiority, if his attempts of mastery of new skills have failed. Under favorable circumstances, the child emerges with a basic feeling of competence.

The Fifth and Final Stage, covers the ages 12-18. The crucial task of this stage is for the young person to integrate his or her earlier childhood indentification and experiences in a way that makes sense and provides a certain continuity with the past. The adolescent is faced with forming an adult value system and finding a meaningful and personally satisfying career.(2)

The above is just one conceptual framework for the developmental milestones which lead to the maturity required for functioning in our society. You may not accept Freudian or Erickson's concepts, however, any conceptual framework for understanding the human growth and learning process must deal with the outcomes from unfavorable disruptions of this process. Parental guidance and support or lack of it through this process plays the key role and therefore must be examined along with socio-cultural and environmental factors as they inter-relate to round out the childs development.

The perpetration of abuse at any stage of development can cause a disruption that prevents the orderly movement on to the next stage. Severe abuse may cause the trauma that could be classified as violent, to the extent that the child fails to recover, and functions as an emotional cripple throughout a lifetime unless the proper intervention reverses the process.

Scope of the Problem

The American Association for Protecting Children, Inc.,

recently issued a report, updating the statistics on the incidence of child abuse nationally through Child Protective Services reporting. This material revealed that

> "in 1984 an estimated 1,726,649 children were reported for child abuse and neglect to Child Protective Services Agencies in the United States and participating jurisdictions. The rate of reporting is estimated at 17.3 children per 1,000 United States child population in 1984. Similarly, an estimated 1,024,178 families were reported in 1984. The total number of families is a general indication of the level of activity on the part of C.P.S., each roughly correspond to the number of investigations performed."

The report further indicates that there has been an increase in levels of reporting of 158 percent between 1976 and 1984, the only years for which the information is available.(3) These totals include both substantiated and unsubstantiated cases with the exception of one State.

Among the characteristics of children reported with major physical injuries in 1984, it is significant to note the average age was 5.3, there were 54.2 percent males and 45.8 percent females. The perpetrator being a parent constituted 82.9 percent of the total, 5.1 percent other relative and 12.1 percent other. Single female headed families constituted 27.8 percent and the racial background was as follows:

White	57.5%
Black	21.9%
Hispanic	11.2%
Other	9.5%

Reported characteristics for children who were sexually maltreated, average age 9.3, males 21.7 percent and females 78.3%. Relationship to perpetrator, own parent 55.6%, other relation 18.7% and other 25.7%. The racial breakdown was as follows:

White	74.7%
Black	13.0%
Hispanic	8.8%
Other	3.5%

Single female headed households constituted 24.53%.

Reported characteristics for Emotionally Maltreated Children in 1984, average age 8.5, relationships to perpetrator, own child 90.3%, other relative 3.4%, other 6.3%. Racial breakdown:

White	71.4%
Black	12.8%
Hispanic	13.2%
Other	2.6%

Single female headed families 39.95%

Reported characteristics for Neglected Children in 1984. Average age 6.41, males 51.5%, females 48.5%, relationship to perpetrator; own child 91.3%, other relative 3.8% and other 5.0%.

Racial Characteristics:

White	62.5%
Black	22.5%
Hispanic	12.9%
Other	2.2%

Percentage of single female headed families 51.12%.(4)

This volume of children reported for child abuse and neglect represents a monumental effort on the part of communities to identify children needing protection as well as an enormous demand on CPS systems nationwide to investigate the reports and provide protective services. Although data are not available, it is clear that the resources of CPS agencies have not increased 158 percent since 1976.

Yet even this enormous volume of reporting does not approach the number of actual child victims estimated through survey research. The recent Gelles and Strauss analysis based on the Louis Harris survey methods suggests there were 1.5 million children subjected to severe physical violence within their families in 1985 --- seven times the number reported and identified as physically injured by CPS agencies nationwide.(4)

Parent Profile

We must now look at some of the characteristics of abusive parents in order to gain some perspectives on our original premise. Most of us here today have a threshold for tolerance and if pushed far enough could be capable of being violent. However, under ideal circumstances we are able to maintain control over our impulses and find another way to handle the problem. What happens to erode this layer of control? What other influences play a significant role? We are a product of our cultural inheritance and therefore tend to emulate our own upbringing. Many abusive parents were themselves abused as children, some physically, sexually or a combination of both. The tendency here would be to accept extreme forms of physical punishment as normal. Some parents failed to receive adequate

nurturance and emotional support resulting in the carry-over of unfulfilled needs into adulthood. If a parent is emotionally insecure and fearful of rejection, they tend to isolate themselves resulting in added pressure on the family unit. A parent may also reach out to the child for fulfillment of unmet needs for love and nurturance and abuse the child out of anger and frustration when these needs are not met. This places in a special risk category the child with special needs of their own, such as the handicapped or developmentally-delayed child.

Abusive parents may have strong feelings of insecurity and low self-esteem resulting from an inability to meet the expectation or goals set by themselves or family members. We must also look at the influence of the environment with its myriad of frustrating social systems impinging upon the marginally-adjusted family. The breakdown of a marriage, homelessness and stress resulting from the parents attempt to escape through alcohol or drug abuse, are events which may bring about child abuse.

> It has been shown, in a nationally representative sample of 1146 United States parents, that stressful events have a direct correlation with the incidence of child abuse. The greater the number of stressful events occurring in the year covered by the Survey, the higher the incidence of child abuse.(5)

Child abuse occurs across cultural lines, social classes and various age groups. Parents on the low income or poverty level come to the attention of social agencies more frequently and are therefore represented in larger numbers than more affluent parents. They are also less able to deal with certain stressful situations due to lack of resources.

The characteristics listed above can be found in parents who practice physical abuse, emotional abuse, and essential neglect or maltreatment. However, among the sexual abuse families the nature of the stress might vary and reasons for the abuse are more complicated due to the family dynamics involved.

There are many theories on the etiological factors in sexual abuse.

David Finkelhor offers some very interesting theories as follow:

Factor 1. <u>Emotional Congruence</u>
This theory attempts to explain why adults gain emotional satisfaction from relating sexually to a child.

a) The child molesters experience themselves as children and have childish emotional needs.

b) A general sense of low esteem in social relationships; relating to the child gives them a sense of power and control.

c) The molester needs the relationships with children to overcome a sense of shame, humiliation or powerlessness that he experienced as a small child at the hands of an adult. This process is called, "identifying with the aggressive."

Factor 2. Sexual Arousal to Children

a) Some theorists feel that sexual arousal to children may be intrinsic. However, this is very controversial as many people are not aroused when they see naked children.

b) Earlier sexual experience which cause imprinting or conditioning to find children arousing when they become adults.

c) Critical experiences associated with traumatic victimization in childhood.

d) The abuser grew up in a family where a role model victimized other children such as siblings or cousins.

e) For those predisposed to pornography, the depiction of sex with children might increase the strength of their arousability.

Factor 3. Blockage

a) Oedipal dynamics. The molesters have intense conflicts about their mothers or "castration anxiety."

b) The person who was impotent in their first sexual attempt or was abandoned by a first lover associates adult sexuality with pain and frustration. He chooses children as a substitute.

c) Moralistic concerns may prevent the abuser from seeking sexual gratification outside of the family. These same concerns may prevent him from using masturbation for gratification.

Factor 4. Disinhibition

a) Alcoholism, senility, psychosis and poor impulse control are cited as factors.

b) Situational factors causing great personal stress due to unemployment, loss of love, death of a relative, etc.

c) Feminist Theories
These theories highlight certain social and cultural elements which encourage or condone sexual behavior directed toward children. Many men see families as private institutions where the fathers have socially sanctioned authority over women and children to treat as they wish.(6)

One could question the viability of anyone of these factors when viewed alone. However, some elements in each, when reviewed together, could provide a possible explanation as to why an adult would choose a child as a sexual object.

The Child Victim

When a child has been traumatized by physical abuse, there are certain observable symptoms in addition to the obvious bruises or broken bones. They tend to be fearful of adults, demonstrate extreme aggressiveness or withdrawal, act out in school, and have difficulties in maintaining social relationships. The very young may be listless and display poor eating habits. During elementary and junior level schools, many of these children are reported for aggressive acts against other children:

Case Example

Sam is a 14 year old and is currently placed in a diagnostic center, having lived in several foster care and group homes. His mother was 16 when she gave birth to him out of wedlock. His father married his mother after he was born, but left shortly after and failed to maintain contact. Sam recalls many beatings with a belt, perpetrated by his mother. She also threatened him frequently that she would "sign him away" or "send him Upstate." He lived at various times with both sets of grandparents and experienced no consistency in caretakers. Prior to placement he was described as violent in school and a frequent truant. The agency psychologist described him as depressed, angry, irritable and diagnosed him as "adjustment disorder" in a child who had been

psychologically and emotionally neglected and abused. He was assessed further to have low average to average range in intelligence. Sam finally stole a car and with a friend deliberately attempted to wreck an agency vehicle by ramming it. He was placed in a psychiatric ward in the City Hospital after he assaulted a police officer.

His way of reacting to the world around him was through acting out his rage against authority figures including those trying to help him. Sam's mother continued to punish him by refusing to permit him to be medicated and by being uncooperative with the agencies trying to help Sam.

NEGLECT

The neglected child is frequently left unsupervised for extended periods. The child might be dirty or poorly dressed. Neglected children are sometimes listless, appear tired, fail to attend school, may be hungry and steal food. The older neglected child might engage in delinquency, vandalism, drugs or alcohol and prostitution. These children may also be a prime target for victimization by adults other than their parents.

Case Example

Mrs. A was referred to Child Protective Services because she repeatedly left her three children unsupervised and neighbors became concerned. The children were ages 4, 6, and 8, and were seen in the street late at night, described as dirty and frequently hungry. Upon investigation, the allegations were found to be substantiated.

Mrs. A received public assistance, had been abandoned by the children's father and subsequently became involved in drugs. She ultimately became a CRACK addict and used most of her money to satisfy this habit. The children had to be removed and taken into protective custody. Upon examination, they were found to be malnourished, had not received the necessary immunizations and the six and eight year old children had missed many days in school. They all manifested emotional problems and developmental delays.

Further history revealed that Mrs. A had been a victim of sexual abuse as a child, was alienated from her biological family and had never

experienced a satisfying adult heterosexual relationship as she consistently became involved with men who abused and abandoned her. She was greatly relieved when the children were placed and in spite of efforts to involve her in treatment, remained resistant and finally disappeared. The children remain under the jurisdiction of the Commissioner of Social Services.

Emotional Abuse

This category of abuse is the most difficult to determine. It involves ignoring, terrorizing, degrading the child and engaging in tactics that undermine the childs self-confidence, resulting in feelings of worthlessness and low self-esteem. It may accompany physical abuse and neglect as well. With very young children, one indication may be failure to thrive. The childs symptoms usually include appearing overly compliant, passive, clinging or exhibiting extremely aggressive or demanding behavior. There can be a disruption of development emotionally and intellectually and in extreme cases, suicide attempts may take place.

CASE HISTORY

For this case example I offer a case as outlined by James Garbarino in his book "The Psychologically Battered Child."

> Teddy was separated from his mother at two and lived in a series of foster homes. When he was seven, his mother came to ask him whether he would like to live with her again. By this time he had a new half-brother and half-sister and a new stepfather. Teddy did decide to live with her. For a few months, everything was all right, but then the stepfather grew increasingly resentful of Teddy. He made Teddy ask for permission before doing anything - standing up, sitting down, or going to the bathroom. He refused to let Teddy join the Boy Scouts or visit friends. Teddy's mother (a problem drinker) did not want any trouble by opposing her husband due to the difficulty experienced in getting him to take Teddy in. When he brought home things he had made in school or when he requested help with his school work, his stepfather made fun of his efforts or called him stupid. At age eleven, after four years of this treatment Teddy was admitted to the emergency room because he had swallowed a can of turpentine. His parents described it as an accident, but the emergency room staff suspected that is had been a suicide attempt.(7)

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SEXUAL ABUSE

Sexual abuse is defined as inappropriate sexual contact with a child involving fondling, intercourse, rape or sodomy. It also involves caressing, indecent exposure and showing pornographic materials. In most cases of sexual abuse the perpetrator is known to the child. The child may be infected with venereal disease or manifest other symptoms such as bruises to or bleeding from the genitals, pain, torn clothing, or may be pregnant.

The child experiences nightmares, has poor peer relationships, loss of appetite, aggressive or disruptive behavior, withdrawal, running away, poor performance in school. Younger children may display an unusual knowledge of sexual matters.

CASE HISTORY

> Debra is a five year old female who was brought to the emergency room by her mother because of a vaginal discharge. Following admission is was determined that she had a venereal disease. The child said her stepfather had molested her. Initially the mother would not believe her. The child was placed in protective custody and court action was initiated. The mother was not too cooperative after her husband was arrested. Both parents were evaluated psychologically, revealing that the mother was 15 when the abused child was born and had 2 successive children by different men. She had a very negative relationship with her own mother and knew little about her biological father. She had been seeking support and approval from the men in her life and was very dependent on Mr. B. Mr. B was not incarcerated as the court case resulted in a dismissal. Neither parent continued in treatment as recommended by the Protective Service Agency and no follow-up treatment was ever provided for the child.

The four case histories all demonstrate the theme of this presentation that emotional traumatization can be viewed as a form of violence. Five year old Debra will probably grow up to complete the cycle of abuse because of her unresolved conflicts brought on by her victimization. Sam has already demonstrated through his acting out of unbridled rage that he was seriously traumatized. Teddy committed an act of violence against himself following his traumatization by his stepfather and his mother's passivity. The three neglected children of Mrs. A will no doubt remain in foster care for many years, having suffered traumatization through deprivation of maternal love and nurturance.

Conclusion

We have looked at various aspects of child abuse including the personality factors that seem prevalent among abusive parents. We cannot conclude this paper however without also looking at the societal abuse as represented by: infant mortality, poverty, malnutrition, homelessness and the very overwhelming problem of substance abuse. New York City's Queensboro Society for the Prevention of Cruelty of Children started receiving Child Protective Service Cases with allegations of neglect due to CRACK abuse in large numbers during the summer of 1986. We took a survey for 6 months. One hundred and nineteen reports of abuse were received during this period and in 41 of those cases the allegations involved substance abuse, mainly Cocaine or Crack, a deadly form of cocaine. This deadly substance takes complete control of its victims and many mothers would leave their children unsupervised without food and other necessities. In the City of New York the number of children reported to be born addicted to drugs more than doubled between a six-month period in 1985 and the same period in 1986, from 407 to 895. The number of court cases charging abuse and neglect of children rose 48 percent in 1986 and in two-thirds of the cases the city's Human Resources Administration found that drug abuse was involved. Over all, the number of reports of child abuse in 1986 jumped to 45,000 from 36,300.

Parents who are suffering from interpersonal problems and conflicts are not able to cope and resort to acting out their frustration on their children. The child is victimized by two systems: the family and the society. The resulting feelings of powerlessness contribute further to the cycle of abuse creating a more intensive kind of trauma and hopelessness. Social and health care agencies are caught in the middle of a socio-economic, politically determined method of service delivery that precludes every effort towards prevention. There is always an attempt to apply the band-aid following the traumatization and injury. The sociological factors will continue to escalate, thereby frustrating our attempts to reverse the process unless some serious thought is given to prioritizing human needs by all levels of government and the development of realistic programs of intervention.

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REFERENCES

1. Oates, K. "Child Abuse, A Community Concern", Brunner/Mazel, Publishers. (New York: 1982, page 4).

2. Erickson, Erik H. "Identity, Youth and Crisis", W.W. Norton and Comp. Publishers, (New York: 1968, Chapter III).

3. American Association for Protecting Children, Inc., "Highlights of Official Child Neglect and Abuse Reporting", American Humane Association, Publisher, Denver, Colorado (1986, page 2).

4. Ibid., (pages 19 through 27)

5. Straus, M.A. and Steinmetz, S.K., "Behind Closed Doors: Violence in American Family", (New York: Doubleday, 1980).

6. Finkelhor, David, "Child Sexual Abuse", The Free Press, Publishers. (New York: 1984, pages 38-45.

7. Garbarino, Guttman and Seeley, "The Psychologically Battered Child", Jossey-Bass, Publishers, (San Francisco, California and London: 1986, page 39).

MASOCHISM AND BATTERED WOMEN: REALITY OR MYTH?

Mary Beth Denniston, M.S.W.

The problem of battered women is not a new social phenomenon, as violence against women has occurred for centuries. What is new, however, is society's awareness of the extent of the problem. This has been a direct result of the efforts of feminists and grass roots activists who have worked tirelessly in the past decade and a half to raise the consciousness of society about the plight of battered women. There have been many attempts to understand the reasons for battering and several explanations have emerged. This writer has been particularly concerned about the frequent labelling of battered women as "masochistic" not only by lay persons in the community but also by members of the helping professions. The following paper is an attempt to address the issue of masochism in battered women. Is this belief valid or is it another form of blaming the victim?

It is important to define what is meant by the term "battered woman." Lenore E. Walker (1979) defines a battered woman as a "person who is repeatedly subjected to any forceful physical or psychological behavior by a man in order to coerce her to do something he wants her to do without any concern for her rights." Walker adds that the couple must go through the battering cycle at least twice, since any woman can find herself battered once. If she stays in the abusive situation and it occurs a second time, she is defined as a battered woman. It has now been found that battered women are present in all age groups, races, ethnic and religious groups, educational levels and socioeconomic groups. Also, violence against women is a seriously under-reported crime. Susan Schecter (1982) cites that an estimated 2 million women in the U.S. are battered annually. It is also one of the only crimes in which the perpetrator lives with the victim.

The correlation between battered women and masochistic behavior has been suggested frequently by those well-intentioned professionals who are attempting to help and understand the woman's situation. This correlation is not surprising when one views the Freudian belief that all women are masochistic, at least on an unconscious level. The Random House Dictionary of the English Language defines masochism first as sexual masochism, "the condition in which sexual gratification depends on suffering, physical pain and humiliation" and second as "the gratification gained from pain, deprivation etc., inflicted or imposed on oneself, either as a result of one's actions or the actions of others, especially the tendency to seek this form of gratification."

Freud (1912) believed that man's sexuality and pleasure can be developed fully as soon as the woman is degraded. He held that man's need to feel powerful and potent feeds on the subjection of women. The sadism of men and masochism of women were instinctual and rooted in the unconscious, according to Freud. This seems to imply that neither men nor women can prevent their sadism and masochism. According to Irene Gilman (1980) Freud viewed masochism as the woman's way of avoiding Oedipal feelings because she fears losing her mother's love. So she provokes the male father figure's aggression to punish herself for desiring her father and to show her mother that she has given up that desire. Freudian theory continues to have a profound effect on counselors attitudes toward battered women. Beverly Nichols (1976) describes how social workers, because of their acceptance of the Freudian view that women are masochistic and provoke the abuse, often ask the batterer what the women did to provoke them and often accept the batterer's explanation. Paula Caplan (1985), a leading researcher on women's masochism, totally refutes the Freudian position. She believes that masochism in women is a myth and that we need to reassess the assumptions about women and find other reasonable ways to explain their behavior. Caplan believes the myth serves two purposes. First it leads men and women to believe that women are deeply and inevitably pathological. Second, the myth serves as a powerful block against social action that could help women. It perpetuates woman's problems, including battering, as being caused by deep rooted psychological needs rather than the social institutions which promote inequality between men and women.

According to Caplan most behavior labelled masochistic is actually one of the following: (1) the ability to delay gratification and wait for rewards and pleasure or to earn happiness through effort; (2) the capacity to put other people's needs ahead of one's own; (3) the belief, based on past experience, that what one has is about all one can expect to get; (4) the effort to avoid punishment, rejection or guilt. If these behaviors are applied to battered women, one can have new insights into why the woman stays in the abusive situation. Rather than masochism, the seeking of punishment, the woman may stay because she fears further punishment. For example, if she leaves, she fears that her husband will find her and kill both her and her children. It is not masochism but socialization which teaches women, from childhood on, to stay in their place and "not make a fuss"; in effect, to take what is offered to them. To ask for something is to be accused of nagging, but altruistic behavior is highly valued in women as they are taught to put the needs of men and children first. Women are more likely than men to be held responsible if anything goes wrong in the relationship. Witness the prolific articles in women's magazines on how to improve a relationship, save a marriage or attract a man. Popular psychologists such as

Dr. Joyce Brothers are continually advising women on how to enhance their marriage. This places the burden of maintaining the relationship directly on the woman. One cannot find the same emphasis on relationships in men's socialization.

Thus the battered woman gets some strong societal messages about her own blame in this failed relationship. If only she had been the good wife, was quiet, made better meals, kept the house cleaner etc.,maybe she would not be beaten. The battered woman often believes that she somehow brought out the violence that was in the man.

Susan Schecter (1982) maintains that women have no political context in which to view their battering experience. The woman believes this is her own isolated struggle, and again that somehow it is her personal failure rather than the unequal power dynamic between men and women which allows the battering to occur. These women seek affirmation and protection from their men. When this fails, the women feel shame and guilt for not fulfilling their primary role to keep a man happy and to be protected by him. This shame and guilt is a very private experience for the woman. She does not reveal her situation as she believes no one else has this experience and no one wants to know about it. Schecter believes that the source of the problem is not the woman who is beaten, but rather it lies in the person who beats, in the traditions and sexist socialization that maintain the abuse and in the institutions that support male domination. One cannot deny the intimidation which violence elicits in women nor the power men have over women to withhold money, food etc. Under capitalism most women either are wageless or earn low wages. They are responsible for the home life and are not paid for this work. Thus an undervaluing of women's work is set up along with an unequal division of labor. Being economically dependent on a man sets up the conditions that reinforce his power over the woman. Along with this power, the man believes he has the right to dominate and use violence against the woman.

Dr. Elaine Hilberman (1980) found that most battered women believe violence is normal and that it happens to most wives. The wife views her man's violence as rational because he is physically or mentally sick, alcoholic, unemployed or under other stress. The violence is justified to these women because they feel deserving of it due to being "bad", provocative or challenging. Also, the violence can be controlled if the woman somehow is "good", quiet and compliant enough. It is ironic that these women would believe male violence is due to stress, illness, etc., but few women would justify their own violent behavior on such grounds.

Given that battered women have a distinct belief system and that masochism may very well be a mislabel for other explainable

behaviors, one may question why does the battered woman stay in her situation? The answers are as varied as the women themselves. However, Del Martin (1983), a pioneer researcher into the battered women's problem cites fear as the common denominator in all of these victim's lives. Martin comments that fear is the most readily understandable explantion yet is also the most commonly disregarded one. Fear can immobilize and rule the woman's every action. Economic reasons may play an important role in keeping the battered women with her batterer. She may have no way to support herself and her children. Also she may fear that leaving would deprive the children of their father. In addition, the woman may feel that something is seriously wrong with the batterer and that leaving him would be to desert him in his need. She has the illusion that she can somehow help the batterer change his behavior. Many battered women are isolated and dependent on their husbands. They have few friends due to the possessiveness of the husband. Also they believe if the one who loves you treats you so badly, then what would the outside world do?

Dr. Dan Dutton and Dr. Susan Lee Painter (1981) propose a theory of traumatic bonding to explain why the battered woman may stay in the situation. These researchers found that physical abuse leaves the woman emotionally exhausted and physically hurt and therefore desperately in need of warmth and comfort. When the woman in this state is offered some warmth and affection by the abuser, (who himself may be feeling guilty), she bonds with the man due to her extreme need. It is not to the abusive side of the man with which the woman bonds, but it is to the affectionate side. This meets her healthy need to be loved and cared for. This is in contrast to those who would say she stayed due to her masochistic need to be physically abused.

Another theory which has been proposed to explain the reasons for staying with a battered man is the theory of learned helplessness. Lenore Walker describes this as a three phase cycle of violence. First there is the slow, tension building phase. This escalates until there is an explosion of physical assaults. The second phase is the calm, loving respite in which the couple reconciles. The man shows kindness, asks for forgiveness, and promises to change. The woman wants to believe this and is ambivalent about leaving him. If she stays, the cycle begins again. If she seeks help but cannot get it, or if her coping mechanisms have no effect on the batterer, she feels the violence is completely beyond her control. Thus she behaves passively and submissively, feeling hopeless and helpless. Walker cautions that the learned helplessness syndrome is the result of the beatings and not the cause of them.

There are several psychological factors cited by Nicole Walton-Allen (1984) which make it difficult for the battered

woman to leave. There is shock that the one who claims to love her can treat her so badly. To leave would be to acknowledge the terrible reality of the situat'on. The woman feels guilt that she somehow contributed to her own beatings by fueling her partner's anger. She is often depressed about being in a hopeless and joyless relationship. This depression makes it more difficult to help oneself. There is a feeling of shame that someone could be so against her as to beat her and leaving would be acknowledging this to the world. There is humilation that she allowed herself to be in this situation. Finally, the battered woman may have low self-esteem which keeps her physically and psychologically immobilized and locked into the relationship. This low self-esteem shades her ability to look at her life and to problem solve in a rational way.

It seems apparent that viewing the battered woman as masochistic denies the true understanding of the psychological, social and political dynamics that play into the battering situation. Presently there is an intense controversy in the mental health community in revising the Diagnostic and Statistical Manual of Mental Disorders (DSM III). This is the handbook which classifies various psychological disorders. The terms masochistic personality disorder and self-defeating personality disorder have been relegated to the DSM III's appendix rather than its main text. The terms noted in the appendix are those which are considered controversial and under investigation. Feminists fought the label masochistic personality disorder as being imprecise and stigmatizing as it could be used to blame women, especially abused women, for societal failures. Psychoanalysts argued that the modern clinical definition of masochism is not a desire for suffering but simply an inclination toward self-defeating behaviors. Also these analysts state that masochism is no longer overly linked with femininity. However, the feminists argue that most people still associate the word masochism as an enjoyment of pain. The American Psychiatric Association acknowledged that the word "masochistic" held too much historical connotations and thus changed its term to "self-defeating" personality disorder. This was defined as a "pervasive pattern of self defeating behavior, beginning by early adulthood and present in a variety of contexts. The individual may often avoid or undermine pleasurable experiences, be drawn to situations or relationships in which he or she will suffer, and prevent others from helping him or her."

Teresa Bernardez, a Michigan State psychiatrist, argued that most patients who may exhibit self-defeating behaviors have a core problem of low self-esteem rather than a need to be hurt. Therefore if a therapist can boost a persons' self esteem, the so called "self-defeating" characteristics would be alleviated. Also, according to Bernardez, people who appear to be hurting themselves are in fact reacting quite rationally to a defeating

environment. Battered women are the group that Ms. Bernardez and others fear most likely to be misdiagnosed as having self-defeating personality disorders. For example, an abused woman may stay with a violent man because she fears that leaving will place other people in danger. This happened in one instance when a batterer made good his threat to burn his in-laws' house down when his wife left him. The woman may refuse gifts from the batterer and become depressed by his offers. She has learned that violence towards her comes in cycles and she is awaiting the next round of violence. However, in refusing the gifts, the woman is exhibiting one of the characteristics described as self-defeating behavior. In addition, an abused woman who is labelled self-defeated might be stripped of custody of her children as the Courts have drawn heavily from the DSM III manual in their decisions.

To appease the critics of the label self-defeating personality disorder, the authors revising the manual noted that this diagnosis should only be made if the behavior did not occur in response to or anticipation of physical, sexual or psychological abuse. This disclaimer was still not acceptable to feminists as they objected that battered women often do not discuss their abuse early in their therapy due to guilt and fear of discovery. Also, the reaction to abuse may persist for years after the violence stops, thus blurring the diagnosis further. A therapist who decides that a client is self-defeating may actually increase the client's problems as it adds another layer of guilt to her experience.

There are arguments on both sides of the issue. Lenore Walker states that psychoanalysts and clinical psychologists come out of quite different traditions and contrasting ideas of what constitutes evidence. What psychoanalysts call empirical data, the clinical psychologists call clinical consensus. Both sides concede that more research is needed. In the meantime the term "self-defeating personality disorder" has also been relegated to the appendix rather than the main text of the DSM III manual. This debate will continue and in the 1990's when the next revision occurs, there may be another battle. At present it is now unknown whether those terms used in the DSM III appendix will be eligible for insurance reimbursement.

Clearly, due to deep rooted Freudian beliefs, battered women and masochism will continue to be linked in spite of the vehement protests of feminists and in spite of the wealth of literature decrying this practice as victim-blaming. However, perhaps through the present controversy over revising the DSM III manual, conscientious mental health professionals may consider the profound sexist roots of battering as found in the socialization of women and men along with the social, economic and political structures that oppress women. It is important for the battered woman and her therapist, to see herself not as

a masochist but as a victim of a sexist oppression and the resultant lack of power. To be battered is to be in a hostage situation with the batterer being the terrorist. One does not question how the hostage causes her suffering but rather why the terrorist is allowed to continue his actions. In this writer's opinion, masochism in the battered women is a myth but an almost universally believed myth. However, as Eric Fromm is reported to have said "the fact that millions of people take part in a delusion does not make it sane."

BIBLIOGRAPHY

Caplan, Paula J. The Myth of Women's Masochism. New York: E.P. Dutton, 1985.

Dutton, Donald, and Painter, Susan Lee. "Traumatic Bonding: The Development of Emotional Attachments In Battered Women and Other Relationships of Intermittent Abuse," Victimology: An International Journal 6 (1981), pp. 139-55.

Franklin, Deborah. "The politics of Masochism", Psychology Today, January, 1987, pp. 53-57.

Freud, Sigmund. "The Most Prevalent Form of Degradation in Erotic Life." In Phillip Rieff (Ed.), Sexuality and the Psychology of Love. New York: Collier 1978; original published 1912, p. 62.

Gilman, Irene. "An Object-relations Approach to the Phenomenon and Treatment of Battered Women," Psychiatry 43 (1980), pp. 346-58.

Hilberman, Elaine. "Overview: The Wife-beater's Wife Reconsidered," American Journal of Psychiatry 137 (1980), pp. 1336-47.

Martin, Del. Battered Wives. New York: Pocket Books, 1983.

Nichols, Beverly. "The Abused Wives' Problem," Journal of Social Casework, 1976, pp. 27-32.

Schecter, Susan. Women and Male Violence, Boston: South End Press, 1982.

Walker, Lenore E. The Battered Woman. New York: Harper and Row, 1979.

Walton-Allen, Nicole. Personal Communication to author Paula Caplan, 1984.

"CREATIVE MYSTIQUE"

John M. Keil

Two years ago a book of mine was published. It's called "The Creative Mystique: How To Manage It, Nurture It And Make It Pay." For reasons that in themselves are somewhat mystical this somewhat less than monumental publishing event resulted in my being asked to speak at the National Symposium on Child Development in Cleveland, and in putting together that event, I discovered that most of my audience had a lot in common with me. They had spent a good part of their lives working with children. I have spent a good part of my life working with creative people. Sometimes I think they're one and the same, and sometimes I think there's a complete role reversal. The children are more creative-and the creative people act more like children. The children are more creative because they're not walled in by creative restrictions that seem to start building up early in life. The creative people are more like children because the practice of creativity is very visceral, very fragile and often very emotional. And this leads, on more occasions than I care for, to child-like procrastination, petulance or perpetual temper tantrums in the offices of my creative people. Children become creative quickly in the way they can handle orders, instructions or criticism. They learn how to dodge, divert, tap dance and make excuses. Creative people in ad agencies have to develop it even farther. They have to learn to live with criticism. And I think we've learned well.

Anyway, my job has been to try and manage, nurture and make productive a creative kindergarten in one of the world's larger advertising agencies. Sometimes it works and we produce such treasures as the Toyota jump or "Where's the beef" or Mcgruff, the tired, careworn, rain-coated dog whose stentorian command urges all of us to "take a bite out of crime". And sometimes it doesn't work and we come up with such monuments to mediocrity as "better buy butter `cause butter is better," or "Oxydol - gets things white, whiter, whitest."

Now what I did in Cleveland was to try and equate some of the things I've learned as both a participator in and director of the creative efforts of an advertising agency to the field of child development. The objective was to discuss ways of encouraging creativity in children. It was fun and challenging. I'd never done anything quite like it and we came up with some interesting approaches.

We found out that the kids whose right brain were stimulated, began to look at things and try things differently.

They began to zig in a zagging world - which, incidentally is the title of a new book I'm writing which has to be finished in two weeks so that you can enjoy it for Christmas.

It has to do with ways of unleashing creativity in all of us - even those who say "I'm just not creative, I don't have a creative bone in my body".

But enough of the commercial. Today we're going to try and do some zigging in your field. We're going to talk about you, the social worker and how you can better market yourself.

This is a classic problem that we in advertising are faced with everyday in everything from toilet paper to Toyotas. How to market them? How to get the public to accept them? This is where the tough thinking comes into play - and sometimes it leads to the kind of thinking that sounds like something out of Alice in Wonderland.

But back to the problem at hand --- I think the first thing we have to do is figure out what the problem is. Is it that you're having a hard time explaining your program? Is it that people don't take your program seriously? Is it that people don't take you seriously? Is it that you, as Rodney Dangerfield says, "get no respect?" Do you have an image problem? Aha! Of course you do.

You are looked on as liberal, impractical, busy-body, do-gooders who spend more time discovering problems than solving them. And you're always bringing the poor into things. And you don't shave your legs. That's the image.

I know all of this because my wife is a Certified Psychiatric Social Worker in New York state.

She uses Nair.

Now, in the advertising business, when we have an image problem like this, we develop a strategy to use as a road guide to where we're going. In fact, we use this strategy format as the starting point of every piece of creative work that we do. And you can too. There are 5 steps to it. Here's how it works.

STEP 1: What are the public perceptions or influences that may influence your creative thinking?

STEP 2: Who is your audience? Whom do you want to influence?

STEP 3: What do you want this audience to do?

STEP 4: What is the core idea--The main thing that will get the audience to do what you want them to do?

STEP 5: Why is this principal thought valid? We call this the "because" section. "Oxydol get clothes white because it has green bleaching crystals." "The Toyota Camry is one of America's best car values because it has the country's lowest incidence of repairs."

Now sometimes the "because" section is emotional. "Wheaties are good for you because it's the breakfast of champions." OKay--got it. That's the strategy format. What are the public's perceptions or influences? Who are you talking to? What do you want them to do? What's the main thought that'll get them to do it? Why is the main thought valid? Now let's apply this strategy to the social worker problem.

You have, as I understand it, an image problem with many different publics. Let's narrow it down. Let's apply it to nurses. As I understand it, nurses in general give social workers in general, a hard time. Why? Is it because of some of the pre-conceived perceptions that I talked about earlier? You're impractical and they see you as bringing them problems they don't need. Perhaps--but I think that it's more than that. I think it's because they see the social worker as competition. Right? You are a threat because you know things that they don't know and because these might get in the way and inhibit rather than help their work. You're a threat because by not understanding your role, they're a bit afraid and in awe of you.

Ok. So let's say that our overall objective is to get nurses to accept you as a part of the patient care team.

Now back to the strategy.

STEP 1: What are the perceptions that may influence our thinking? Nurses see social workers as a threat.

STEP 2: Who are we talking to? Nurses who, through their work, come in contact with social workers.

STEP 3: What do we want them to do? We want them to accept you as a part of the patient-care team.

STEP 4: What is the core idea? The main thing that will get the audience to do what we want them to do.

This is the crux. This has to be the heart of our effort. I think the main thing is that they should accept you as a part of the patient-care team not because you can offer them help--not because you know things they don't know--not because you're caring people but rather because you do not represent a threat to them.

STEP 5: Why is the principal thought valid? You are not a threat to them because--why? Well, probably because you're not trained nor are you experts in the field of nursing.

Now, you'll notice that in this exercise in strategy development, I haven't once gotten into the execution or the real creative part. This is not a part of strategy development. Let me illustrate the difference between the two.

We recently did a commercial for the New York City Hospital Corporation's Infant Mortality Program. Briefly, the strategy was to encourage pregnant mothers to avail themselves of New York City's new Pregnancy Hot-Line--because this could help them have healthy babies. The idea was to have the camera pan along a row of babies sitting on pillows and giggling and cooing as they stared at the camera. Happy baby music would be playing in the background and the announcer would say something like: "Last year over 113,000 babies were born in New York City." Suddenly the camera, in its slow pan, would reveal no babies. Just empty pillows with a rattle here, a sweater or blanket there. The music would stop and the announcer would say: "Some were born too early, some too small--and some died." Silence. Empty pillows. Then the camera would pick up more babies going "goo goo" "gaga" and the music would start up again and the announcer would say: "But it might not have happened if their mothers had known about the Pregnancy Hot-Line. If you're pregnant or know of someone who is, just call 230-1111. Because healthy babies start before they're born."

You'll notice that essentially the creative execution--the commercial--dramatized the strategy. Brought it to life. Got audience attention by showing the babies and then the empty pillows. We got the audience's attention and then communicated with them. Attention-getting and communication are the heart of advertising's creative process. But there was also an interesting attention-getting communications problem in the making of this commercial.

We needed twenty 8 to 10 month-old babies. Ten for the commercial and ten for backups in case something happened to the first string. We hired a miracle baby lady who is one of the premier baby casting people in the country. She lined up the kids on the stage with their catchers under the front lip of the stage. Each child had to have a catcher in case he or she got curious and suddenly crawled to the edge. The director was nervous. The cameraman was nervous. I was nervous. But the casting lady was calm and cool. The kids were doing what kids do. Staring, crying, exploring each other's hair, falling over sideways and, in general, not helping our cause.

We wanted to do this in one long take, just moving slowly along the line--but it seemed impossible to me. I was about to settle for a number of short takes that we could splice together when the baby lady turned and said, "you ready?". We held our breaths and nodded and she turned to the kids and suddenly shouted, "AWWWWWRRRRIGHT you kids!" They stopped what they were doing and looked at her in amazement. She had their attention.

She was communicating. Then she started to slowly walk down the line next to the moving camera, talking all the while. "Look at me. Now sit up and grin. Jonathan, where's your finger?" (Jonathan grins and points finger). "Betsy, where's your hair?" (Betsy pats her head). And so forth. It was astonishing. The kids stopped and started and did things and before I knew it, we had our commercial. She knew how to get attention and communicate.

Now, in my vivid description of the actual commercial, notice that we didn't do some things that we might have done.

(1) We did not use a hard hitting informative approach. You know, an authority figure --- possibly even a doctor saying, "in the next 30 seconds I'm going to list five things that can make a big difference whether or not you have a healthy baby ..."

(2) Or the scare approach. Open on a camera panning around an antiquated and dirty bathroom. It passes by the toilet and up to the wash basin where we see rubber tubing and a needle and syringe. A hand picks up the tubing and wraps it around a bare arm. The needle is picked up and approaches the vein. The announcer says, "in the next 30 seconds, the time it takes heroin to circulate in the blood stream a baby, growing in its mother's womb could begin to be deformed ..."

Both of these approaches would be on strategy --- urging mothers to avail themselves of the pregnancy health line. But the first one, we felt, was not emotional or involving enough. In fact, commercials that have a spokesperson saying, "in the next 30 seconds I'm going to list ..." get tuned out right about there, even if the spokesperson is Ronald Reagan.

The second one, while emotionally involving, centers more on birth defects--which is being effectively handled by the March of Dimes--rather than the General Prenatal Health of Mother and Child.

So we chose to dramatize the straight statistical scare approach. Empty pillows...this could happen to your baby...an approach that touches the hidden fear of every pregnant mother-to-be.

Ok, back to your problem of the social worker and the nurse. After we've worked out the strategy the left side of the brain passes the ball to the right side. "Ok. I've worked out the strategy for you. The basis on which to build. Now it's your turn to do something. Show us some dramatic social workers in action. Show us how they---". Right side says: "Wait a minute, left side, don't tell me how to do it. That's my job. Stop while you're ahead. The trouble with too many left sides is they don't know when it's time to turn things over to the creative forces."

Now what does the right side say or do? What kind of execution do we come up with?

In this short time, it would be presumptuous of me, representing the right side, to come up with the answer---even if I could. In our business we spend a lot of time wrestling with these problems. But there are certain things you might want to consider. First of all, the media. How is the best way to reach your audience, the nurses? A TV commercial? No, too expensive. Too much waste. If you're trying to tell the whole country you're no threat to nurses, that would be different. But you're not. The whole country doesn't really care whether the nurses' lives are made better or worse by your presence.

We might consider ads in selected publications that are directed to nurses like: The American Nurse, The American Journal of Nursing, or Nursing Life. Or we might select some kind of a direct mail program. Again, probably not. Too expensive. Too hard to cut through the clutter, the barrage of junk mail we all receive daily.

We might consider a lecture or workshop program for the nurses set up by the hospitals with mandatory attendance, or a video tape cassette directed specifically to nurses.

Now, if we were to work on a zigging approach, we might say to ourselves "What can't a social worker do for you?" or "What can a social worker not do for you?" Then describe the functions that the nurses think are impinging on their work lives. This leads to such approaches as:

"5 things a social worker can't do" or "why a social worker is not a nurse" or "are social workers a threat to the nursing profession?" or "how social workers can hurt you" or "the nurses prayer: Please protect me from mistakes, malpractice, and social workers."

Now, just looking at these headlines, I'll guarantee they'll get more attention from the nurses of America than such approaches as:

"The social worker - an important part of your team" or "how your social worker can help you be more effective" or "you have nothing to fear but fear itself" (although that may not be too bad) or "the caring social worker: a profile."

Notice, by the way, that of these last four approaches, only one of them, "You have nothing to fear but itself" is truly acceptable because the other three are off strategy.

Remember the core idea of the strategy. "The social worker is not a threat to nurses." When you're working on creative approaches, always keep the strategy in front of you.

Obviously in the reverse twist approaches that we've suggested, we would start by explaining what a social worker doesn't do (why they're not a threat), but we would always end with what a social worker does do, how they can help, how they can complement the nurse, how they can and should be a part of the patient-care team.

One last thought. One of the ways to further develop this kind of creativity is through group stimulation or brainstorming sessions, and the secret of good brainstorming is flexibility. Stay loose. Never say no. Let the ideas flow and build on one another.

With me, the most important time to be flexible happened a few years ago in the Trinity Alps of Northern California. We were shooting a commercial for Hamm's beer featuring a 300 pound Kodiak bear. Those of you who live west of Chicago may remember the campaign. Man strides through the land of sky blue waters with the bear as his companion. He stops somewhere along his route and enjoys a Hamm's in a woodsy bar or at a lumber camp or on a fishing dock. Then he starts off again down the long road of life with the bear at his side, and this was no trained dancing bear, either. He was what is known as a "conditioned bear." Had all his teeth and toenails or claws as they are called. The film crew went out early and I arrived a few days later. Producer greeted me with a description of the shots. I asked where the bear was. He said, "first shot will be with a telephoto lens watching the man coming over the hill and suddenly revealing the bear next to him."

"Fine" I said, "Where's the bear?"

"Next shot will be looking down at the stream as the bear crosses on a log."

"Rod, where's the bear?"

"Then we'll do another long shot ..."

"The bear. Where is he?"

He looked at me...and then down at his shoes.

"I dunno."

"Ya dunno? Whadya mean ya dunno?"

"I'm not sure of where he is.

Blood pressure elevated. Wild thumping of heart. $30,000 a day for film crew and equipment and the star of the show, the Kodiak bear, is missing.

"You lost the bear?" I said incredulously.

"Not exactly lost. It's just that we can't get an airline to fly him out here. (Bear came from Alberta but had been "conditioned" on a farm in New Jersey.)

"How'd we get him from Alberta to New Jersey?"

"Air Canada. They'll fly in anything. But they don't fly from N.Y. to L.A. But we're working on it."

Now here's where creative flexibility came in. What to do. Shoot a man in a bear suit? No good. Shoot the commercial without the bear? No good. The bear is what makes the commercial. Shoot the scenes in the bar without the bear first and pray that the bear would arrive somehow while we were vamping. Ok. Then the word came. The bear was on the way. The trainer and his assistant would drive them up in an Econoline van. Be here at nine o'clock. Rejoicing and whoopee. We had dinner and waited.

Nine o'clock and no bear. Ten o'clock and no bear. Go to bed. Don't worry. Probably heavy traffic. One o'clock in the morning. Everyone wide awake and staring at the ceiling. Then a noise. The grinding of an Econoline van on a logging road. HUZZAH! They're here. We all rushed out as the van chugged up and stopped. Hooray, we said and started for them. The door swung open and the trainer and his assistant staggered out. "Oh gawd, Oh gawd!" They said as they lurched away from the van.

"Earl!" we shouted. "What's the matter?. And then as we got ten feet away we shouted "Oh gawd, oh gawd!" and staggered backward. The bear had gotten car sick and had vomited and defecated all over the inside and its occupants constantly for 120 miles. And they couldn't stop because no one knew anything about California laws and transporting bears.

The bear spent the next two days recovering flat on his back with his feet in the air. So we rewrote a couple of scenes and shot close ups of his face as he slept it off. Again creative flexibility at work.

And so we come to the end of this sojourn of marketing the social worker. From it, I hope you've gotten suggestions on how to approach this, or any creative problem, strategically and creatively. I must say that for me it's been a creative challenge developing his talk because other than the fact that I'm sometimes accused of having the brain of a prenatal child (fetus?) I've had very little experience in your field. But I do hope that the last 45 minutes will inspire you to get more experience in my field, which is creativity.

Thank you.

"SEXUALITY, CHILDBEARING, AND FAMILY PLANNING ISSUES FOR PHYSICALLY CHALLENGED WOMEN"

Lucy C. Spruill, M.S.W.

This paper is concerned with service delivery issues in the areas of sexuality, childbearing, and family planning from the perspective of physically challenged women who are the recipients of services in these areas. Information for this paper is drawn from the author's personal experiences in living with a lifelong disability as well as professional experiences working with a group of sixteen women receiving prenatal and postpartum services from a public health high-risk pregnancy program, and with twenty women seen as part of the author's private practice in offering consultation to organizations and agencies which serve disabled clients. All thirty-six women were "physically challenged," with a wide range of disabilities including spinal cord injury, polio, spina bifida, blindness, amputations, muscular dystrophy, and hearing impairment. Twenty-two of the women were single, four were divorced, and ten married at the time services were given. Twenty-three of the women had at least one child. I will limit the scope of the paper to a discussion of the issues in maternal and child health for physically challenged women, without attempting at this time to describe solutions or services.

In the area of sexuality, the major issues for disabled women are in the areas of the development of an identity as a sexual person, sexuality education, and victimization. The general lack of accessibility in society is probably the single largest factor for disabled women in the development of a positive sexual identity. We all get most of our sex education and our identity as sexual persons not from educational materials and experiences, but from day-to-day opportunities to talk with, interact with, and observe others. The lack of access which results in an absence of visible role models for disabled young women, in diminished opportunity to talk and interact with peers with and without disabilities, and in segregated services in the areas of transportation, education, and recreational and leisure activities hinders this whole process. One ends up with inadequate relationship skills, no context derived from experience and observation in which to place sexuality concerns, and an overreliance on media as a field of observation with regard to sexuality. While the influence of media is a problem for everyone in the area of sexuality, media's overemphasis on physically beautiful bodies and what I call the "Some Enchanted Evening" model of relationship formation is particularly harmful for disabled women who don't place themselves anywhere in these images. The plot is further thickened by the fact that women's worth in this

culture is equal to her worth as a sex object and being held worthless as a sex object and worth something only as a sex object have the same effect on self-esteem: one feels disregarded and worthless as a whole human being.

Sex education materials for disabled consumers and professionals who work with disabled individuals seem to swing from one extreme to another, with no middle ground. Either the materials are overly clinical descriptions of the sexuality of the disabled only in terms of anatomic and physiologic deviations from what is considered to be normative, or they are written in the style of teenage magazines twenty years ago, with lots of vague platitudes like "avoid wearing plaids and bright colors because they call attention to your body," "keep a cheerful smile," and "drop something when you want a man's attention." Neither type of material is very helpful to the disabled women who needs specific help in creating a satisfying sexual experience with a partner. Materials which are specific but not clinical, which are relationship-oriented, written from the perspective of the disabled reader, and which discuss the subjective and psychosocial nature of the sexual experience are sorely needed. Disabled women often look at sex education materials to find out if their experiences are "normal". We can do them a service to acknowledge that there probably isn't any such thing and instead to talk about sexual experiences in terms of whether they are satisfying in terms of the woman and her partner's individual personal needs.

Professionals and family members have many concerns in the area of victimization of disabled women. It is important to realize that assertiveness, self-esteem, and the ability to observe and be in control of situations are more important defenses than physical power in threatening situations. It is important to be aware that physical and sexual assault are committed by individuals who have problems with power and its use and not problems with sexual arousal. Women who are not considered physically attractive are not safe. It is important that women's shelters and all services for victimized women be accessible to the handicapped. Finally, it is important to realize that the most common victimization experiences of disabled women are exploitive relationships, the best defense for which is a strong, healthy sense of self-esteem and, again, assertiveness and the willingness and ability to control and direct the course of one's own life.

Childbearing issues for disabled women begin with the need for accurate, nonjudgmental information in the areas of fertility and genetics. Almost all of the women from whose experience this paper is derived were pleasantly astonished to find they were pregnant. They had usually been told by medical practitioners that they <u>couldn't</u> get pregnant. (In my own work with disabled teenagers, <u>I tell</u> them to always assume they are fertile whatever they may have been told, and to act accordingly!) Most had not been able to get accurate genetic

information, or even honest admissions from doctors that they really didn't know what the genetic risks were. Most had been subjected to negative judgmental comments about the appropriateness of disabled women having children, and were offered sterilization and abortion procedures when they sought prenatal care. To say that this sets up poor communication between disabled pregnant women and their caregivers would be an understatement.

The disabled woman who has chosen to have a child needs much emotional and physical support. The decision to have a child is, in its best form, an expression of healthy narcissism that lies behind the often misunderstood scene in Children of a Lesser God in which Sarah, the deaf central figure in the play, says she wants deaf babies. She likes and accepts herself the way she is and would accept and like children who are that way, too. Most disabled women, however, will listen to much disapproval and fear from family and friends when they are having a child. Most of the women I have worked with have had the experience of "concerned" friends and family calling hospitals, child protective agencies, and other professionals and expressing the opinion that the woman should not be allowed to take her baby home and care for it. Most disabled women fear the intervention of child protective agencies most of all. The new mother is then placed in the position of not feeling safe enough to express her own normal nervousness, concerns, or ambivalence and having to adopt a superficial air of confidence and self-assurance to protect her relationship with her child. The kinds of physical and emotional supports that disabled parents need most are:

(1) physically accessible spaces in which to rear children; including physically accessible, subsidized housing units suitable for families;

(2) funding for aids and appliances which would be helpful to disabled mothers, such as lowered nursery equipment, "cry lights" for hearing impaired mothers, instructional materials which are available in Braille for blind mothers;

(3) access to and control over necessary services such as homemaking, attendant care, and transportation;

(4) acknowledgement of homemaking and childrearing as valid occupational choices by state vocational rehabilitation agencies, with accompanying services and benefits of such agencies;

(5) affirmation of their competence as parents and of the values of cooperation, helpfulness, sensitivity to others, and acceptance of differences which often prevail in families where one member has a disability;

(6) discussion of child management techniques which emphasize the development of a positive parent-child relationship, use of behavioral reinforcers, nurturing qualities of helpfulness and cooperativeness in the child, and good communication skills.

Professionals in maternal and child health should be aware that women with disabilities hear the emphasis on the prevention of birth defects and the arguments around treatment of handicapped newborns in a very different way than professionals, and that we are aware that the lived experiences of adults with disabilities are ignored as these arguments go on around us. I quote from an emotional letter to the editor of Ms magazine in response to an article about Baby Doe, a child born with spina bifida for whom the parents sought to withhold treatment:

> Few things make me feel more utterly desolate and abandoned than the resolve to support the choice to abort deformed fetuses or not to treat deformed infants. Yes, I know all the arguments. I am pro-choice, too, I say. Yet I am severely disabled. Deformed. My mother would have aborted me, too, if she could have. My movement, the disability rights movement, is weak because there are so few of us involved in fighting the kinds of stereotypes that persuade people that they could never cope with such a child. We are no match against either the pro-choice movement or the pro-life movement, both of which are better organized and neither of which really understands what it feels like to be one of that group that everyone else is glibly fighting over. We still have no voice. Sometimes, lying in bed at night, executive job and all be hanged, I simply cry about this. I think that everyone should get involved in fighting handicapism in society. And I mean really involved, not just on the board of some mental retardation facility, but involved in fighting for attendant care, better education, accessible mass transit and housing. We can't say it's okay to be disabled, and mean it, and not want to bear a disabled child. It's simply a contradiction. We have to resolve this issue first. The way we're resolving it now allows no room to make a better world for people with disabilities. For the hope, conscious or not, is that maybe, someday, there will be none of us left.

In the area of family planning, attention must be given to the accessibility of the space in which services are given, the appropriateness of particular methods in light of each woman's physical needs and other treatments she may be receiving, and

the practical usability of the method for her. Most of the time professionals will have to ask the patient herself to get an accurate assessment of these factors. Family planning services should take place as a part of life planning--for how many children one wants and when, how much time and energy one has, and other plans the woman may have for herself in terms of a career, education, etc. Family planning can then be seen by the disabled female patient as the useful tool it is rather than an attempt on the part of others to control her life choices or prevent her from reproducing.

In conclusion, I would suggest that professionals can draw on the natural creativity and problem-solving abilities of patients with disabilities in approaching maternal and child health situations--they've been at this longer than you have, in most cases. It is useful to be aware, too, that the subjective experience of living with a disability is probably very different than one imagines. Listen to disabled clients for what their experiences really are, as distinct from professional concerns. Books such as With the Power of Each Breath and All Things Are Possible (listed in the bibliography), which are well-written subjective accounts of the life experiences of disabled women, are a useful addition to professional material. Finally, the best approach to the fears and concerns we all have in working with clients whose experiences are different and unfamiliar to us and who have conplicated special problems, is to express and acknowledge those concerns and join with the disabled patient in realistically solving her special problems with sexuality, childbearing, and family planning.

BIBLIOGRAPHY

Browne, Susan E., Debra Connors, and Nanci Stern. With the Power of Each Breath. Cleis Press. Pittsburgh 1985.

Disability Rights Education and Defense Fund, Inc. No More Stares. Berkely 1979.

Duffy, Yvonne. All Things Are Possible. A.J. Garvin and Associates. Ann ARbor, MI 1981.

Fine, Michele and Adrienne Ash. "Disabled Women: Sexism Without the Pedestal," J. of Sociology and Social Welfare. V. 8, no. 2, July 1981.

Gliedman, J. and D. Roth. The Unexpected Minority. New York: Harcourt, Brace, and Jovanovich, 1980.

Gordon, Sol and Douglas Bilden. Sexual Rights for People Who Happen to be Handicapped. Ed-U-Press. New York 1979.

McCarthy, Barry W., Mary Ryan, and Fred Johnson. Sexual Awareness: A Practical Approach. Scrimshaw Press. San Francisco. 1975.

Task Force on the Concerns of Physically Disabled Women. Toward Intimacy: Family Planning and Sexuality Concerns of Physically Disabled Women. Human Sciences Press, New York 1978.

Task Force on the Concerns of Physically Disabled Women. Within Reach: Providing Family Planning Services to Physically Disabled Women. New York 1978.

CASE MANAGEMENT FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS: AN OLD, NEW SOCIAL WORK FRONTIER FOR THE EIGHTIES (OR ZIGGING TO SUCCESS IN A ZAGGING WORLD)

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The issue of case management is gaining new importance and recognition within the public health field as well as within the private health sector. A recent report entitled Technology - Dependent Children - Hospital v. Home Care - A Technical Memorandum" (May, 1987) cited the need for a better definition of the role of case manager along with the proper assurances that the case manager be able to balance the interests of the family, the third-party payer, and other involved parties. Complexities in providing health care to children with special health care needs have made case management an economic and service delivery issue for programs and an important issue for social workers in refining their role within the medical arena. The need for social workers to define and build skills in case management was noted by Kumabe (1985) in Public Health Social Work in Maternal and Child Health - A Forward Plan. A recent workshop in public health social work in maternal and child health cited the need to clarify and redefine the role of the social worker as a case manager and a discharger planner (See Current Issues in Health Care for Professional Leaders, 1986, p.88). The focus of this workshop is current issues of case management in health care. Clearly, we as social workers must better understand recent developments in case management and why it is now a critical and contraversial topic within the private and public health care arena.

We will focus on the common issues surrounding case management. Our discussion of case management will address the following areas: Definition of terms, barriers and obstacles, social work role and function, social work knowledge/skills and the social work practice implications. The intent of the discussion is to develop a better understanding of the critical issues and elements of case management in the delivery of care to children with special health care needs and their families.

Definition of Terms

Many controversial issues surround the definition of terms that identify and explain the process of case management. It is not unusual to hear this process referred to as "Case Management", "Care Management", "Service Coordinator", and/or Followup". An important question to answer is: Do all these terms mean the same thing?...A survey conducted by the Task Force on the Future Directions of Services for Children with Special Health Care Needs recently attempted to clarify what terms were used to identify the process of case management.

They found that only 40% of those surveyed had a written definition of case management. However, 30% of those answering "NO" had a written definition of something they called "Care Management, Case Coordinator, or Care Coordination."

How might we better define these terms? What do we mean by case management? Is case management a method of dealing with a particular population with a specific problem or set of problems? Is it a series of tasks that are concrete in nature, such as a review of records to validate quality assurance? Should it be a function of a particular position, discipline, program? The 1976 Joint Commission on Accreditation of Hospitals defined case management as:

> ...activities aimed at linking the service system to a consumer and coordinating the various system components in order to achieve a successful outcome. The objective of case management is continuity of service...Case management is essentially a problem solving function designed to ensure continuity of services to overcome systems rigidity, fragmented services, misutilization of certain facilities and inaccessibility.

Increasingly there is recognition that the success of discharge planning for complex health care cases rests with the quality of the plan developed along with the ongoing cooperation of the patient, his/her family, and medical providers. The success of these two variables are frequently dependent on the quality of the individual professional and the resources he/she can orchestrate for patient care needs. This would seem to indicate that in fact, case management encompasses all of the above; that is, it is a method, and a process which blends specific tasks and functions. Perhaps a more appropriate definition for social workers dealing with children with special health care needs is the one developed by the group at this workshop; that is, "case management is the development and provision of a care plan that describes the problems, objectives, resources and outcome criteria. They key to effective case management is the established relationship between consumer and social worker in the development of a plan that ensures a team approach and achieves the desired outcomes. Advocacy and coordination of services are built in".

Barriers and Obstacles

Given a working definition of case management the next major issue to explore is the barriers and obstacles to effective case management in social work practice. There is considerable discrepancy between the principle and practice of case management (Berdie, 1983). In principle, a patient only needs one case manager at any given time to advocate and obtain appropriate services and programs, many of which may extend across agency and program lines. While unintended, the current

fragmentation of programs and categorical system approach in caring for the complex, multi problem child does not support a case manager approach. In practice the fact is that many children will have several case managers working for them, while others will have none. The discrepancy between principle and practice in case management continues to flourish and remains an unresolved issue because of the increasing economic barriers and obstacles to care.

Certainly, the multiple definitions and terms used to identify case management as a service are major obstacles/barriers to its consistent incorporation within health care settings, but there are many other factors which create barriers to this approach to care. Notably, case management as a service is difficult to quantify. It is a costly, time consuming process which frequently cuts across many types of service programs involving the cooperation, communication and commitment of multiple agencies and staff in the delivery of care. This issue, perhaps more than any other, may be at the crux of "turf struggles" and allegations that it is not a cost effective service. There is need for a data base to specifically document barriers to health care for patient/families. Failure to delineate patient/family needs with an appropriate psycho-social profile over time, only continues to perpetuate the vagueness with which case management is considered by program administrators. Furthermore, inadequate or negative communication occurs on the part of the service providers who strive to design and deliver a service that is in the best interest of patients needs. It is not enough to believe in the patient/families best interests. We must clearly document it.

Decreasing dollars for comprehensive programs and staff along with changing roles among health care professionals has fueled and highlighted the "turf struggles". It has become an economic struggle for survival grounded by specific discipline and agency. It is no longer feasible to think in a traditional manner about job duties and funding sources. "Turf struggles" occur in the larger program struggle to obtain "lead agency" designation. An issue to be raised within this struggle is whether duplicate services are being created because of a need to be fiscally sound versus a need to serve a particular patient population. Case management raises another obstacle--that of sanction/authority--Does the case manager have the necessary authority to do the job? What agency can best represent the patient/family amidst large caseloads whose size may prevent the frequency and type of contact necessary to best serve the specific case needs?

In spite of the above barriers and obstacles, the benefits are equally clear for utilizing a family centered case management approach for children with special health needs. Coordination of service results in a better mix and more timely

delivery of care. There is frequently greater compliance and followup on recommendations when someone is identified as a "synthesizer" and "transmitter" of information between the patient/family and other professionals. An open discussion of alternative resources among providers creates more service options from which to choose in both the public and private sector. Declining resources both at monetary and staffing levels are not demanding coordination between public and private providers. Case management is the crucial process by which the health care team can provide care that greatly enhances the patient's level of functioning. It helps the health care team deliver interventions that ease the family's difficulty in coping with a chronically or terminally ill member. Some specific benefits of case management are: determination of the appropriateness of a treatment or a facility; promotion of the physical and emotional well being of the child and family; avoidance of fragmentation of care; and recognition that well informed families make fewer inappropriate demands on the system and more intelligent decisions relative to the member's care (Henderson and Wallock, 1987).

A collaborative approach to case management between the public and private sector can open up previously closed doors. Collaborative efforts have generated interest and support for the development of a data base to support the value of case management interventions through validation of the critical variables, i.e., quality assurance, standard setting, prevention, and cost containment and greater consumer satisfaction. Other indicators of quality case management interventions include: an increase in interagency agreements to reduce duplication of services; a decrease in service gaps; a refocusing of interventions in support of more cost effective family-centered and community-based care resulting in a reduced number of hospital days, repeat hospitalizations or inappropriate medical tests incurred by individuals not under the case management system.

The literature clearly indicates that positive parent-child relationships decrease incidence of abuse and other problems while promoting a more productive life span for chronically ill and handicapped individuals by which all society will benefit. The specific quality indicators for effective case management intervention that facilitates a family centered relationship include: shared decision making; consumer satisfaction surveys; individualized service plans geared to meeting total psycho-social needs to support intact family units.

Clearly, identification of increased quality of care and/or benefits from case management to established delivery systems is difficult to quantify. In general, we have had difficulty with this and social workers have not paid enough attention to quantifying their services for benefit/cost. For years we have been divided as a profession between the identity and the value

of a social worker as a psychotherapist, as a clinician, or medical health professional...as though it is not possible to incorporate all three. We have created a schism in social work function between activities defined as "process-oriented" and activities defined as "task-oriented". Betsy Anderson identified this dilemma quite clearly when she defined social work as..."the development of internal resources while identifying external resources" and furthermore..."There's always been ambiquity because some (individuals) have placed greater emphasis on one rather than on the other; there seems to be more status attached to the internal resources." (Rodman and Murphy, 1986. p. 35). Consequently, as a profession, we lack a cohesive identity in terms of what we do, the value we ascribe to what we do, and how individuals benefit from our interventions. No wonder we have had difficulty demonstrating values on our case management services.

Worker Role and Function

In today's changing health care delivery climate, increasing emphasis is placed on outpatient care rather than on the traditional lengthy inpatient care. Traditional roles of health professionals are undergoing much scrutiny and change. The future will see an increased emphasis on issues of prevention; on outpatient surgery; and on the high technological biomedical interventions. These changes are creating an economic impact that is changing the role and function of disciplines that have historically delivered and defined health care services. Case management is one such health care service. Social Work has historically assumed the responsibility of providing this service. Our professional training and practice in such areas as interviewing; communication; psychodynamics and knowledge of community resources give us unique expertise to create and develop resource networks which enable us to work with and care for patients and their families.

Rosalind Miller emphasized that..."No other health discipline has the depth of knowledge and skill to provide the services required by these cases, of which the case management role is seminal." (Rodman and Murphy), 1986, p. 106).

Case management requires coordination and maintenance of the package of services provided to the patient/family. Case management can be rendered by an insurer, a pediatrician, a parent, a social worker or some other health care professional. The comprehensiveness of case management and the respective goals, depends on the sanction and training of the given case manager. (Technology Dependent Children: Hospital vs. Home Care - A Technical Memorandum, 1987).

The role and function of a case manager may vary by how the client is identified...by an individual professional...by a particular service system...or by an advocacy group. Who the

provider is determines the means and parameters for outreach and whether the case management will reflect a supportive, specialist, therapeutic, or generalist model (Levine and Fleming, 1986). Whatever model is selected will vary with the focus of each agency per its philosophical and fiscal limitations. In some agencies the case manager may enlist community resources to assist the family and patient while in others, the case manager may assume responsibility for all case management functions or be assigned a single component of the case management process. Regardless of the chosen approach, case management should encompass the following six basic functions: Client identification and outreach, assessment of social-emotional, environmental, medical and financial needs, service planning; contacting formal and informal linkages with needed services, monitoring of service delivery; and advocacy at both a patient and a systems level.

Frequently, confusion arises when the basic functions of case management are translated into roles. It is important to remember that a case manager provides and/or is actively aware of all six vital functions, and does not address a particular function in isolation. The roles of advocate, service broker, technician, assessor and enabler are all part of basic case management functions and require a professional well versed in the arts of flexibility, diplomacy, and creativity. Understandably, education and training vary by profession and by discipline with the respective preparation given as the rationale for why a particular discipline is better qualified to serve as case manager. However, nothing works more against the spirit of collaboration, necessary for effective case management, than professional territoriality. There is a strong consensus that a team approach to case management involving professionals of various backgrounds and expertise is optimum for the child with special health needs and his/her family.

Unfortunately, case management activity is usually assigned on the basis of just one issue or problem for the patient, e.g., educational needs, medical needs, psycho-social needs. The impact of castastrophic illness and advanced technology on how services are being delivered forces us to recognize that effective service delivery crosses many boundaries of expertise. The child with special health care needs will have difficulties that are educational, medical, and psycho-social and will continue to need case management services for extended periods of time. The child also operates within the context of a family unit. He/she cannot be isolated from the context of that unit for the mere utility of programming or compliance to a particular regime. Family needs as a whole must be considered in developing the service plan because they, as well as the child, will be affected by its implementation.

Knowledge and Skills

It is difficult to discuss the role and function of case management without addressing the requiste knowledge and skills. Necessary knowledge and skills are tied to the particular focus of the agency providing "case management". A survey conducted by the Task Force on the Future Directions of Services for Children with Special Health Care Needs revealed that case management training is mainly on-the-job. Social Work (66%) and Nursing (82%) were most likely to be designated as case managers. Clerical, technicians, administrators, and special educators were also identified (16%). Only 38% reported getting formal training for case management. Subsequently, professionals from a variety of backgrounds are assigned to the task of case management. Given the focus of the provider agency, knowledge and skills of the case manager may be limited to the major mission of that agency, i.e., medical, educational or psychosocial, all of which are important components in serving a child with special health care needs. If, however, these components are not delivered in tandem it leads to fragmentation of services and frustration for the patient and family. Too often the unfortunate outcome is either a duplication of or lack of needed services.

Case management skills draw from many knowledge bases. Fundamental skills include: 1. interviewing and diagnosis 2. networking 3. evaluation techniques and 4. management abilities. These basic skills are in addition to the technical/professional body of knowledge necessary to provide optimum patient care. Characteristically, programs tend to assume that professionals with the specific "problem related" degree can automatically be effective case managers. It is crucial that agencies take the time to understand the role and function of case management to better determine the necessary skills for the job. Case management skills can result from professional training, e.g. social work, or it can result from experience and disposition. In the latter case, the agency must carefully assess the individual's ability to understand and relate to the situation from a wholistic viewpoint which incorporates the patient, the family, the agency networks, the community and the social/political climate within which the service is delivered.

A case manager must have the skills to be many things to many people beside the patient. While being a broker of services within the external systems, the case manager must also be able to be a mediator of services within the internal system or home agency. Since effective case management is done via an interdisciplinary team approach, skills involving collaboration, facilitation, and conflict resolution are important. It is equally important that the case manager function with the appropriate administrative sanction which usually means the case manager becomes the communicator to the process and structure

for the provider agency. To function within that role while simultaneously serving as patient/family advocate can frequently be conflictual. Consequently, the case manager must be able to operate within therapeutic and managerial boundaries which by their very nature may be contradictory. Continued effectiveness as a case manager demands ability to think in a quantitative manner, knowledge of and ability to utilize formal and informal systems, ability to balance therapeutic interventions within managerial constraints, and ability to work well with professionals with different backgrounds, experience, and agency settings.

Practice Implications

Case management is designed to assist in the coordination of services to patient/families. Does this mean that all patient/families equally need the assistance of a case manager in order to utilize the services offered? How are decisions made to provide assistance to one patient/family over another? As caseloads for services grow and as the health care system becomes more complex, it becomes even more difficult to know what services are available and how to negotiate between services for the optimum mix. Families experiencing significant psycho-social distress are not able to effectively use the services offered through the health care system. Subsequently, families not effectively using the health care system place themselves and other family members at higher risk for biopsychosocial problems. Hence the cycle continues unbroken. Psychosocial assessment tools can assist with targeting our interventions to break the vicious cycle. Assessment tools also can be important means for documenting that we as case managers are reaching those most in need of assistance. They facilitate building upon an individual's existing strengths. Most importantly they can assist to identify how to better enable patients/families to help themselves. Most often, successful family-centered interventions occur as a result of sharing information....about resources....about quirks in the system....whom to talk to....patient/family rights....alternative solutions.

Clearly, the social work practice implications for case management provide amply room for zigging to success in a zagging world. Social workers should not look at case management with askance. Many creative opportunities that can enhance productivity and family centered care are possible within case management. Too many social workers view case management as an old frontier, but it is important to recognize and capitalize on the potential for case management as a return to a new frontier in the 1980's.

REFERENCES

Berdie, Jane, (ed.) Family Dynamics...In Families With A Child With A Handicapping Condition: A Trainer's Guide, Rocky Mountain Child Development Center, University of Colorado School of Medicine, Health Sciences Center, 1983.

Current Issues in Health Care for Professional Leaders: Problems and Potentials and Changes in Health Care Today: A Challenge to the Profession. Conference Proceedings. Columbia University School of Social Work: New York, N.Y., 5/20 and 6/6/86.

Henderson, Mary G. and Stanley S. Wallock, "Evaluating Case Management for Castastrophic Illness", Business and Health, January, 1987.

Kaplan, Berton H., John C. Cassel and Susan Gore, "Social Support and Health", Medical Care, Vol. XV, No. 5, May, 1977.

Kumabe, Kaz, "Knowledge and Skill Requirements Social Work Practice in Maternal and Child Health" in Alex Gitterman, et al (eds.) Public Health Social Work in Maternal and Child Health - A Forward Plan. Columbia University School of Social Work and DMEH: Bethesda, MD, June, 1985.

Levine, Irene Shirfen and Mary Fleming, "Human Resource Development: Issues In Case Management", Center of Rehabilitation and Manpower Services, University of Maryland in collaboration with Center For State Human Resource Development Community Support and Rehabilitation Branch National Institute of Mental Health. Sponsored by: Manpower Development Unit and Community Support Project, State of Maryland Mental Hygiene Administration, Fourth Printing, May, 1986.

Mazoqay, Jackie M., "Early Intervention in High Cost Care", Business and Health, January, 1987.

Miller, Roslind S., "Generic Framework Issues: Improved Care and Treatment for the Chronically Ill Child" in Doris Rodman and Ann Murphy (eds.), A New Look at Parent-Social Work Alliance: Improved Care and Treatment for the Chronically Ill Child. National Center for Education in Maternal and Child Health, Washington, D.C., 1986.

Newacheck, Paul W., "The Costs of Caring for Chronically Ill Children", Business and Health, January, 1987.

Rodman, Doris H. and Ann Murphy (eds.), A New Look at Parent-Social Work Alliance: Improved Care and Treatment for the Chronically Ill Child. National Center for Education in Maternal and Child Health, Washington, D.C., 1986.

Technology - Dependent Children: Hospital v. Home Care A Technical Memorandum. U.S. Congress: Washington, D.C., May, 1987.

PREGNANT AND PARENTING YOUTH

Pamela Stokes, M.S.S.W.

Adolescent pregnancy and parenthood have become major concerns for today's society. Within the last 15 years there have been numerous research studies, task forces, programs and articles devoted to these particular issues. Teenage pregnancy is certainly not a new phenomenon and, in actuality, the rate of adolescent pregnancy has decreased. What is alarming, to myself and to many professionals, is that the number of single teenage parents has increased and the age of conception has decreased. A large percentage of single adolescent parents receives welfare assistance which may affect their willingness to continue their education and/or desire to obtain a job.

I work at Miami Valley Hospital, a 772 bed acute-care facility located in Dayton, (Montgomery County) Ohio. Montgomery County is Ohio's fourth largest county. Information tabulated in 1980 by the U.S. Census Bureau indicates the following:

TOTAL POPULATION: 571,697

BLACK: 94,702,
WHITE: 471,778,
OTHER: 1,740

MEDIAN AGE: 30.3 - 27.4% under age 18

MEDIAN INCOME: 20,830

BELOW POVERTY LEVEL: 61,900

PERCENT UNEMPLOYED: 12.0 (Dayton-figures not available for Montgomery County)

My areas of responsibility include the maternity areas, a 35 bed neonatal intensive care unit and the women's surgery floor. In 1986, 532 teenagers delivered a live birth at Miami Valley Hospital. Although Montgomery County has several programs for teenagers that provide information, support and resources, before, during and after pregnancy, we continue to maintain high statistics in the area of teenage pregnancy. The Children's Defense Fund recently released the following information:

- Montgomery County has Ohio's fifth highest rate of out-of-wedlock births.

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- Over 25 percent of the county's children live in single parent families, the highest rate among Ohio's 88 counties.

- One in seven Montgomery County babies was born to a teenage mother in 1985. This is slightly higher than the national average.

- Nearly half of the teen births in Montgomery County were paid for by the Medicaid program for low income families.

- One-fourth of the adolescent births in Montgomery County involved teen mothers having their second or third child.

- Nearly two-thirds of the Montgomery County teenage mothers who gave birth in 1985 had not completed high school. Over 40% of the fathers were not high school graduates.(1)

We (Medical Social Services Dept.) recently received a grant from The Ohio Children's Trust Fund to provide a parenting program for pregnant teens. "Teens For Parenting" will be offered as a four week series beginning the first of June. We hope to encourage pregnant teens to participate by offering transportation, child care, refreshments, and a special gift at each session. This project will provide information and support to pregnant teenagers as a complement to their prenatal health care. Education regarding pregnancy, parenting, community resources and life management skills will be combined with discussion of shared concerns and experiences.

Adolescent Development

Adolescence is a period of transition. I remember my teen years as being some of the most difficult years of my life, often struggling for acceptance from my peers, trust and respect from my parents. Adolescents are concerned with the question, "Am I Normal?" and often use their peers as a gauge of normalcy.(2) They are also attempting to discover a sense of self and identity, although their desire to identify with the group, during early adolescence, precludes their need for identity of self.(3)

Teens today receive tremendous peer pressure and subliminal messages from the mass media to engage in early, irresponsible sexual activity. Newsweek (Feb. 16, 1987) reported that for teens, television is a major form of sex education.(4) Whenever I have viewed a television couple engaging in "lovemaking", the lovemaking is always spontaneous, romantic, and there is never a discussion about birth control. Adolescents do not need this type of glamorization about sex.

Sexual activity, as well as drinking, smoking and swearing are marketed by society as behaviors you typically engage in when you are "older". These forbidden activities seem to hold a particular allure for young teens.

Adolescents have difficulty correlating principles with actual behavior, i.e., that pregnancy is a result of sexual activity.(5) At this stage of their development, teens are often narcissistic, concentrating on self. Although their peers may have experienced parenthood, the adolescent believes that they will not become pregnant, because they are "omnipotent".(6)

I work on the maternity floors and often ask teenage mothers after they deliver if they used birth control prior to their pregnancy. The typical response is that they either did not use any type of birth control or that they stopped taking the pill because it "made them sick". Several of these teens seem to have a lot of misconceptions about the birth control pill and the medical dangers associated with it. They are also unaware that there are several types of birth control methods, birth control pills, and that their prescriptions can be changed if they are having adverse effects. Adolescent unplanned pregnancies are often associated with teens' perception of risks, i.e., "you can't get pregnant if you have sex standing up".(7) Some of the teens at our hospital have indicated that they have never used birth control prior to this pregnancy because they had been having sex for years and had not become pregnant.

PREGNANT TEEN

There is some good news! The teen pregnancy rate across the country has been decreasing. The number of teen pregnancies in Montgomery County decreased from 1,580 in 1979 to 1,285 in 1985. The decrease in numbers of teen pregnancies can be largely attributed to an increase in contraceptive use.(8) Although teens experience the highest ratio of abortion to pregnancy than any other age group, the abortion rate is also decreasing for teens.(9) The pregnant teen usually does not come in for prenatal care until after her first trimester which can probably be attributed to an attempt to deny the pregnancy. Inadequate prenatal care is more closely correlated to pregnancy-related complications than age.(10)

After the pregnant teen enters our prenatal system, we find that generally the adolescents will keep the majority of their clinic appointments.

Historically, low birth weight infants have been associated with adolescent pregnancy. Bennett & Bardon in 1979 reported that the incidence of low birth weight for infants born to teenagers was approximately 14.5% nationwide.(11) At Miami Valley Hospital, the incidence of LBW (<2500) for teenagers in 1986, was approximately 11%. Except for the teen under 15 years of age, LBW may be more a factor of the psycho-social problems related to teen pregnancy versus a biological age risk.(12)

Unwed teenagers are more likely to make the decision of single parenthood rather than place their infant for adoption. I have talked to teenagers who decided on adoption and they received strong condemnation from their friends concerning their decision. It seems to be generally accepted among most teenagers that the only reason to place a baby for adoption is if the infant is "unloved" or "unwanted".

A 1979 survey of metropolitan-area adolescents indicated that 38% of pregnant teens choose abortion, 49% deliver live births, and 14% end in miscarriages or stillbirths. Of that 49%, 9% of the infants are raised by the teen mother, 6% raised by the extended family (informal adoption) and 4% placed for formal adoption.(13)

TEEN PARENT

One of the greatest concerns that professionals have about teen parenthood is whether an adolescent is capable of adequately parenting an infant. There have been several studies that have concluded that teen parents tend to underestimate the needs of their infant, overestimate their speed of development and that the incidence of child abuse is reportedly higher within this population.(14) What can significantly impact the outcome for an infant of an adolescent is the degree of support the teen is receiving from her family and/or the father of the baby.(15) Here, at Miami Valley Hospital, the pregnant teen's mother is usually very supportive. Often the adolescent may have experienced difficulty relating to her parent(s) prior to her pregnancy but report a closer relationship after the initial shock is resolved.

A large majority of the pregnant teens that we see have been raised by single adult women. There is no longer the stigma attached to illegitimacy that there once was, and for low income youth, no social incentive for delaying parenthood. Actually, adolescents receive validation of their abilities to engage in "successful" adult behavior. They receive approval from their friends and experience an improvement in their relationship with their parent(s).

The father of the baby, if involved, does provide significant emotional support for the teen mother. During the infant's hospitalization, I find that overall, the father visits and participates with the baby's care.

The adolescent father is often neglected by professionals. A study completed by Redmond in 1985 indicated that teen fathers often want to be involved with the pregnancy and will provide emotional and financial support if included in the decision-making process.(16)

After the infant's discharge from the hospital, grandparents often assume partial responsibility for the infant's care particularly if the teen is still residing at home. Their involvement can sometimes create confusion involving roles. The willingness of parents to "raise" an adolescent's child may also contribute to the recidivism rate of teen pregnancy. Newsweek reported that 1/3 of all adolescent mothers will deliver a second child before they turn 20.(17) Our hospital statistics indicate that in 1986 40.5% of the teens that delivered had been pregnant at least twice.

A large majority of our teens apply for welfare assistance or reside in homes that receive assistance from the state. Poverty is cyclical. Teens that continue the cycle of welfare dependence will most likely raise children that as adult, are also welfare dependent.

INTERVENTION STRATEGIES

School-Based Clinics - There are currently 76 school-based clinics in the United States. School-based clinics provide services such as sex education, family planning services, physical examinations and treatment of minor illnesses within the school setting. Some programs also dispense contraceptives and/or provide prenatal care. School-based clinics are extremely controversial. Some of the opponents' concerns are that these clinics encourage early sexual activity and abortions. Proponents believe that school-based clinics will "improve students' health, lower their birth rates, raise their level of contraceptive use and improve their school attendance."(18) Locating family planning services in the school makes it more accessible to adolescents. The school-based clinic model may encourage early prenatal care for a pregnant teen which would significantly decrease prenatal complications. Most importantly, the school based clinic would provide additional resource persons for adolescents to openly discuss concerns about sexuality and sexual myths.

MASS MEDIA - The communications arena has the potential to make a significant contribution to the needs of adolescents. Teenagers are influenced by audiovisual presentations and televison is one of their main resources for information about sex. There need to be advertisements promoting the delaying of sexual activity until a person is able to appropriately handle the responsibility of the potential consequences; perhaps something similar to the advertisements against drugs, "SAY NO TO SEX!". Advertisement of various birth control methods on television, and facilities where they can be obtained, would be extremely helpful for the sexually active teen. For those adolescents who are pregnant, we should promote the positive aspects of placing an infant for adoption and early, consistent prenatal care.

PROGRAMS - The development of programs that provide a supportive atmosphere for teens and an opportunity to discuss issues and concerns is essential for today's youth. Programming that will teach teen parents about infant stimulation techniques, developmental milestones and infant needs are necessary if we are to reduce the incidence of child abuse and neglect. Most importantly, programs need to be available that will involve teens and their parents and assist in communications building and enhancement of their relationship.

SUMMARY

Adolescent pregnancy and parenthood affect all aspects of today's society. If the current trend of "babies having babies" is not discontinued, we may soon have a large population of young adults who are dependent on their communities and have limited options available to them. Communities have to develop intervention strategies and provide programs that integrate resources and systems (family, health, education, etc.) to impact unprotected sexual activity and premature pregnancies.

REFERENCES

1. Children's Defense Fund - Ohio 1987.

2. McAnarney, Elizabeth. Premature Adolescent Pregnancy and Parenthood. Grune & Stratton, Inc. NY 1983, p. 44.

3. Ibid, p. 22.

4. Kantrowitz, Barbara, et.al. Kids And Contraceptives. Newsweek, 1987, p. 54.

5. Anastasiow, Nicholas J. The Adolescent Parent. Paul H. Brooks Publishing Co., MD 1982, p. 22.

6. Ibid.

7. McAnarney, Elizabeth, op.cit., Parenthood. p. 44.

8. Levine, Art. Taking On Teen Pregnancy U.S. News and World Report, March 23, 1987, p. 67.

9. McAnarney, Elizabeth, op.cit., p. 56.

10. Makinson, Carolyn. The Health Consequence of Teenage Fertility. Family Planning Perspective, May/June, 1985. Vol 17, No. 3, pp. 132-139.

11. Anastasiow, Nicholas J., op.cit., p. 96.

12. Makinson, Carolyn, op.cit., pp. 132-139.

13. Flick, Louise, H. Paths to Adolescent Parenthood: Implications For Prevention. Public Health Reports, March/April, 1986. Vol. 101, No. 2, pp. 132-145.

14. Scott, Keith G., Field, Tiffany and Robertson, Evan. Teenage Parents and Their Offspring. Grune & Stratton, Inc., NY 1981.

15. McAnarney, Elizabeth, op.cit., p. 264

16. Barret, Robert L., and Robinson, Byran E. Adolescent Fathers: Often Forgotten Parents. Pediatric Nursing, July/August, 1986. Vol. 12, No. 4, pp. 273-277.

17. Kantrowitz, Barbara, et.al., op.cit.

18. Dryfoos, Joy. School Based Health Clinics: A New Approach to Preventing Adolescent Pregnancy. Family Planning Perspectives, March/April, 1985. Vol. 17, No. 2, pp. 70-75.

PREGNANT AND PARENTING YOUTH

Pamela Stokes, M.S.S.W.

Goals and Objectives of the Presentation

1. To examine the issues of adolescent development in relation to adolescent pregnancy.

2. To evaluate risk factors associated with adolescent pregnancy.

3. To discuss impact of teenage pregnancy on society.

4. To identify resources and support systems available for pregnant and parenting youth.

5. To develop adolescent intervention strategies.

Outline:

I. Introduction

II. Video Cassette: The Vanishing Family: Crisis in Black America, CBS Special Report

Discussion

III. Adolescent Development

-peer pressure
-omnipotence
-evaluation of risk

IV. The Pregnant Teen

-decrease of pregnancies and abortion
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BIBLIOGRAPHY

Adler, Jerry, Katz, Susan, Jackson, Tenley-Ann. A Teen Pregnancy Epidemic. Newsweek, March 25, 1985. p. 90.

Anastasiow, Nicholas J., The Adolescent Parent. Paul H. Brooks Publishing Co. M.D. 1982.

Barret, Robert L., and Robinson, Byran E. Adolescent Fathers: Often Forgotten Parents. Pediatric Nursing, July-August, 1986. Vol. 12, No. 4, pp. 273-277.

Dryfoos, Joy. School Based Health Clinics: A New Approach to Preventing Adolescent Pregnancy. Family Planning Perspectives, March/April, 1985. Vol. 17, No. 2, pp. 70-75.

Flick, Louise, H. Paths to Adolescent Parenthood: Implications For Prevention. Public Health Reports, March/April, 1986. Vol. 101, No. 2, pp. 132-145.

Hewson, Patricia M. Research On Adolescent Male Attitudes About Contraceptives. Pediatric Nursing, March/April, 1986. Vol. 121, No. 2, pp. 114-116.

Kantrowitz, Barbara, et.al. Kids And Contraceptives. Newsweek, Feb. 16, 1987. pp. 54-66.

Kisker, Ellen E. Teenagers Talk About Sex, Pregnancy And Contraception. Family Planning Perspectives, March/April, 1985. Vol. 17, No. 2, pp. 83-90.

Krause, Karen L. A Report On The Governor's Task Force On Adolescent Sexuality And Pregnancy. Center For Women And Children, Winter, 1987. Vol. 10, Issue I, p. 5 & 6.

Levine, Art. Taking On Teen Pregnancy. U.S. News & World Report, March 23, 1987. p. 67 & 68.

Magyar, Patricia H. The Ethical Challenges of Adolescent Pregnancy. Perinatal News, Summer, 1984, p. 3.

Makinson, Carolyn. The Health Consequences of Teenage Fertility. Family Planning Perspectives, May/June, 1985. Vol. 17, No. 3, pp. 132-139.

McAnarney, Elizabeth. Premature Adolescent Pregnancy and Parenthood. Grune & Stratton, Inc. NY 1983.

Mott, Frank L. The Pace of Repeated Childbearing Among Young American Mothers. Family Planning Perspectives, Jan./Feb., 1986. Vol. 18, No. 1, pp. 5-12.

Mott, Frank L. and Marsiglio, William. Early Childbearing and Completion of High School. Family Planning Perspectives, Sept./Oct., 1985. Vol. 17, No. 5, pp. 234-237.

Panzarine, Susan. Stressors, Coping and Social Supports of Adolescent Mothers. Journal of Adolescent Health Care, May, 1986. Vol. 7, No. 3, pp. 153-161.

Polit, Denise F. Routes to Self-Sufficiency: Teenage Mothers and Employment. Children Today, Jan./Feb., 1987. Vol. 16, No. 1, pp. 6-11.

Reis, Janet. Teenage Pregnancy and Parenthood in Illinois. Journal of Adolescent Medicine, March, 1987. Vol. 8, No. 2, pp. 177-185.

Scott, Keith G., Field, Tiffany and Robertson, Evan. Teenage Parents and Their Offspring. Grune & Stratton, Inc., NY 1981.

Weatherly, Richard A., Perlman, Sylvia B., Levine, Michael H., Klerman, Lorraine V. Comprehensive Programs for Pregnant Teenagers and Teenage Parents: How Successful Have They Been? Family Planning Perspectives, March/April, 1986. Vol. 18, No. 2, pp. 73-78.

RECRUITING AND SUSTAINING ADOPTIVE FAMILIES FOR SPECIAL NEEDS CHILDREN THROUGH JOINT PLANNING

Dale Brantley, M.S.S.W.
Emogene Austin, M.S.W.

The State of Alabama has intensified efforts to place more special needs children in permanent adoptive homes. In early 1984 the State had in permanent custody 243 special needs children for whom there were no adoptive homes available. From this total over 50% were identified as older black children, some of whom were developmentally delayed and in need of homes. There were 42 white children who were developmentally delayed because of cerebral palsy, mental retardation, speech delays, birth defects and other health related problems.

The disproportionate number of black children with no appropriate resources available was of major concern to the State's Department of Human Resources (DHR). There had not been a consistent recruitment program in the Black community for homes for black children. Adoptive parents in many counties had not been organized into support groups. Also, in many of the predominantly Black populated counties no one social worker had the specific assignment of providing adoption services. The social worker may have had the responsibility for all child welfare services in that county.

In early 1984 the State of Alabama began to plan a new approach in their adoption program. A joint project to increase the number of adoptions of the State's special needs children was funded by the office of Human Development Services from September 1984 through June 1986. The major objectives of the joint project were:

1. To increase the number of special needs children placed in adoptive homes by as much as 60%.

2. To decrease the length of time special needs children spend in foster care.

3. To decrease the number of disruptions of adoptions by providing supportive help to adoptive parents.

4. To offer more intensive post-placement services.

The participants in the project were the State of Alabama's Department of Human Resources (DHR), the Sparks Center for Developmental and Learning Disorders, University of Alabama at Birmingham (A University Affiliated Program), and Children's Aid

Society of Jefferson County (a private licensed child placing agency), located in Birmingham, Alabama.

The DHR assumed responsibility for recruiting families for special needs children. A social worker from the DHR was assigned full time to the project. Five Alabama counties were selected as "project counties" including those in which there was a large black population. Jefferson County, the State's most populated county was selected, and the other four were rural counties located in the central part of the state.

The Sparks Center provided interdisciplinary services to evaluate and help plan for the adoption of the children. The Center provided some supportive services following the adoption. A training component was developed to train foster parents, adoptive parents and adoption workers on special problems of developmentally delayed children. The training was accomplished through consultation, in-service training and the distribution of media materials.

Children's Aid Society provided support service (Resource Family Network) to families who needed to know more about parenting special needs children. The DHR recognized that disruptions frequently occur when families are isolated, and that many families do not acknowledge their need for help. The adoptive families were informed of this resource network at the time of placement. The resource family was a family who had had experience with special needs children.

Recruitment:

The project demonstrated that there must be a continuous program of recruitment at the County level if the DHR was to have adequate adoptive resources for special needs children. Some of the counties had minimal adoption services and the general public was not even aware that the DHR provided adoption services. Also, staff vacancies at the county level required that other duties be assigned to adoption workers, therefore limiting the time spent on adoption services. During the project period, the five counties gave priority to adoption services and assigned one social worker in each county to assist in the recruitment program.

As recruitment efforts began in the five counties, it was apparent that a major task of the project was to inform the general public about the services of the DHR. Adoption myths were dispelled as placements were made in the community.

Recruitment methods varied from county to county. Rural counties without mass media restricted to some extent recruitment efforts. Personal contacts were most effective in

these counties. Also, the Church as used as a major resource in recruiting families. The local newspapers published several articles identifying the project and featured children in need of adoptive families. Radio stations provided public service announcements and the project director was interviewed several times by the radio stations.

Recruitment in Jefferson County was already in progress when the project was funded. This county is one of the few counties in the state with a specialized adoption staff. The county was already conducting group preparation services and offering post-placement services to adoptive families.

The News media in the Jefferson County area did not immediately respond to the request to give publicity to the project. A Black Newspaper featured a school-age boy and published an article regarding the need for adoptive parents for special needs children. This article created an interest from several T.V. stations and as a result, the project received considerable coverage by the stations.

The counties were all responsive to the recruitment efforts. A total of 70 families completed adoption applications.

Role of the Sparks Center:

The major contribution to the project from the Sparks Center was the provision of clinical services. The Center also provided to the DHR staff consultation, in-service training, and the production of media materials. The Sparks Center, a University Affiliated Center is an integral part of the University of Alabama at Birmingham. The Center provides: (1) interdisciplinary training; (2) exemplary clinical services to individuals with developmental disabilities; (3) dissemination of information on developmental disability; (4) consultation and technical assistance to agencies and consumer groups serving individuals with developmentally disabilities; and (5) applied and basic research in human development. The Center operates a number of specialty clinics and treatment training programs. An interdisciplinary clinic serves as the main clinic and provides direct services to children and adults with developmental disabilities throughout the State.

Clinical services were needed for the project. The DHR estimated that approximately 40-50% of all special needs children in their custody have some type of developmental delay and in many cases they have multiple handicaps. Some of the handicaps found among the special needs children are mental retardation, cerebral palsy, seizure disorders, learning disabilities, speech/language delays and other health related

problems. A few had been identified as having a specific syndrome, i.e., Down syndrome, spina bifida, fetal alcohol syndrome. A large number of these children had been physically, emotionally or sexually abused. The multiple and chronic nature of the handicaps manifested by these children added to the difficulty in locating adoptive homes and in preventing disruptions when the adoption was finalized.

Comprehensive evaluations were needed on a large number of these children. The DHR wanted to know their developmental levels and treatment requirements. The adoptive parents needed accurate information on the children's developmental status, and they needed post-placement services once the adoption was completed.

The children referred to the Center received multidisciplinary evaluations from social work, medicine, psychology, nursing, vision function, dentistry, physical therapy, nutrition, special education, and speech/hearing. As a result of the evaluations, the adoption consultants were able to obtain first-hand information on the needs of the children and in turn have a better understanding of what type of family would meet these needs. The foster parents and social workers attended the clinic and participated in staffing.
A psychologist from the Sparks Center was part of the DHR placement team that reviewed and selected families. The psychologist was available to adoptive families after placement. Several of the adoptive families were referred to the psychologist for consultation in behavior management and assistance in school placements.

The Center evaluated 44 children. Mental retardation at the mild level (55-70) was found in 21 cases; borderline mental retardation (70-80) was found in 17 cases; average intelligence was apparent in five cases while only one child tested at the moderate level of mental retardation.

Speech delays were found to be a problem common to most of the children. Unfortunately, many of these children lived in very rural areas where there were few resources available for speech problems. No major medical problems were evident among these 44 children. One child had a mild scoliosis. Two were diagnosed as having a disorder called Russell-Silver syndrome and two children showed the effects of Fetal alcohol syndrome. Behavioral problems were mentioned as an issue with a majority of the children and was a problem with which the DHR had the most concern and the least success in resolving.

The Sparks Center conducted several workshops, for all project staff, and included the State adoption consultants, Children's Aid staff and the five social workers from the project counties. The first workshop focused on understanding

behavior and some techniques of behavior management. The second workshop focused on special education and included presentations on the interpretation of I.Q. scores, and expected academic functioning based on I.Q. levels. A workshop on play therapy dealt with simple techniques to be used in the home to stimulate development. A final workshop by the Sparks Center's speech pathologist reviewed problems of speech/language delays and methods to assist non-verbal children in communicating.

The Role of Children's Aid Society:

Children's Aid Society provided support (resource family network) to families who needed to know more about parenting special needs children. Through a careful reviewing and matching process, an experienced adoptive family was identified to assist those needing support. The resource families had experience in all areas of adoption and the adjustments that often need to be made. Whenever an adoptive family requested the services of the resource family, Children's Aid worked closely with the placement worker in facilitating this service.

One staff member from Children's Aid had the responsibility for training in the use of the network. Initially, 200 resource families were identified for the network through the DHR's county offices. Each family was sent a profile of the network and a form which requested information about the family that might be useful in matching resource families with new adoptive families. Eighty-seven families returned completed surveys and were invited to attend one of the five parent training sessions.

During the project period, the Resource Family Network matched thirty experienced adoptive families with other families new to adoption. Most of the families served by the network were white; two families were black. In one family the mother was Cherokee Indian and in another case a single male was of Brazilian origin.

Most of the families were married with both parents in the household, but six families were headed by a single parent. Seventeen of the families were parents for the first time.

The Resource Family Network provided a very necessary component to the placement of special needs children. The network offered support to families that were pre-adoptive. It was found that parents needed support prior to the adoption and this support needed to be continuous.

Significant Findings:

The project demonstrated that:

(1) There must be a continuous program of recruitment at the county level if the State is to have adequate resources for special needs children.

(2) The interpretation of adoption programs to the general public was essential.

(3) Child-specific recruitment was effective.

(4) Recruitment efforts had to be adapted to the needs of the particular county.

(5) The actual presence of adoption workers in the churches and communities was effective in recruitment efforts, especially in rural counties.

(6) Diagnostic and evaluation services are needed when children have or are suspected of having developmental delays.

(7) The more successful placements occurred when parents had access to pre and post-placement counseling services.

(8) There was greater community response in counties where there had not been a visible adoption program.

(9) Post-adoptive families were eager to offer "personal testimonies" and to assist in recruitment in their local communities.

(10) The best results in terms of on-going supportive relationships occurred when the family was offered a resource family prior to placement.

(11) Families who adopted infants many years ago needed advice and assistance in talking with their children about adoption.

(12) More foster parents were adopting since subsidies were available.

(13) Families were better prepared through group preparation.

(14) Disruption in adoptions decreased when families availed themselves of The Family Resource Network.

(15) Immediate response should be given to any expression of interest in adoption.

Benefits:

. The major benefit of the project was the recruitment of 70 adoptive families and the placement of 136 children in permanent adoptive homes. This would not have been accomplished without the special emphasis placed on the adoption of special needs children. Many of the children placed through the project were those who had been in foster care for a long period of time.

. The length of time children spend in foster care was reduced. In September, 1985, a total was 918 children remained in foster care more than 72 months; in September 1985, the total was 868.

. The cooperative relationship established between a public agency, DHR, The Sparks Center, a University Affiliated Center, and Children's Aid Society, adoption program. Even though funding for the project has ceased, the Sparks Center continued to provide services to special needs children referred by DHR. The Family Resource Network continued as private funding was secured for this service.

. The recognition of the necessity for a recruitment program on a continuous basis influenced the DHR in employing the project social worker on a permanent basis. This person will serve as a consultant in the office of adoption with the responsibility of recruitment and training county workers in the procedure of recruitment and group preparation of families.

. The project enabled the DHR to define and test effective recruitment methods. Barriers to recruitment were identified and recruitment materials were developed and replicated for distribution throughout the state.

. The DHR was encouraged by the response of families and in realizing there are resources untapped in Alabama for special needs children. Such encouragement should motivate continued leadership toward locating and developing more resources so that more children can have a permanent home.

How a Diagnostic Clinic Helps to Effect The Adoption of Some Children With Special Needs

Cecilia J. Dwyer, M.S.W./A.C.S.W.;L.I.S.W.;M.Ed.

The adoption program I'm going to talk about is located in the University Affiliated Cincinnati Center for Developmental Disorders/University of Cincinnati, and in particular in the Children's Hospital Medical complex, Cincinnati, Ohio.

This adoption program officially began, unfunded and unstaffed, in June 1986, with the plan for its first year's offering throughout 1986-87. Special needs adoption, as you know, is a national initiative. Effort, in particular, is being made nationally, with local public child welfare workers, especially to help increase their knowledge about different kinds of children with special needs. With increased knowledge, the expectation is that child welfare workers within foster and adoptive work, will get to know better those children assigned to their care and work more understandably and enthusiastically to help keep a child within his own family or provide proper care for a child outside of his home, in either foster or adoptive homes. With increased knowledge, the expectation is that child welfare workers will become more aware of adults who specifically request a child who might have a handicap or two, or even be multiply limited.

A child with special needs means different things to different people. Some think of these children as older and many as teenagers; some think of these children as representatives of minorities or varied ethnic cultures. I always think of children with special needs as those who constantly need to be moved from one foster home to another because of behavioral/social problems and/or because of mismanagement problems and disruptive threats to adoptive situations. UACCDD children with special needs clinically refers to those children diagnosed as mentally retarded and/or handicapped by varied developmental disabilities.

In June 1986, when Social Work/CCDD, decided to act as a broker in a medical center to provide adoption information, a meeting was held with representatives of both the foster care and adoptive units of the local Department of Human Services-Hamilton County. While this agency had different ideas about children with special needs, they did pick up on UACCDD's clinical definition and immediately reflected on a number of children in their care. They quickly acknowledged many of their children personified the developmentally disabled, any age, either gender. These representatives agreed to support the idea of UACCDD's proposed brokerage program and to help. Having

gained the public interest, UACCDD's next effort was to alert the private sector child-care agencies of this new program. Without any hesitation, the private child welfare workers also were eager for another kind of information about children with special needs in order to better understand adults' requests about adopting children who might have a handicap. Both public and private child welfare agencies thus acknowledged a need of adults or families expressing interest, expecially in availability.

In 1986-87, five (5) "Consider Adoption Information Meetings" (CAMI) were held in the Children's Hospital Medical Center Complex sponsored solely by UACCDD with input from community-based child care agencies.

Adoption Meetings/CCDD
Statistics

	Professionals	Interested Adults	(Families)	Total	Children
09/23/86	7	15	(11)	22	4
11/18/86	2	19	(14)	21	8
01/20/87	3	12	(8)	15	5
03/17/87	2	6	(3)	8	0
04/21/87	2	5	(5)	7	3
			(One person prof. & parent)		
05/19/87	Cancelled to support Parent Support Groups' sponsored 1 1/2 day workshop, "Who Are the Children; Where Are the Families."				

The meetings were held the third Tuesday, each month 7:30 - 9:00 P.M. These meetings brought together professionals, parents, aspiring parents, interested citizens and children. Meeting announcements were mailed two weeks in advance of the actual meeting to public and private child-care workers in the community with the request to publicize. The meeting notices also were sent to all UACCDD staff/trainees, and to a growing UACCDD mailing roster. Telephone inquiries also were responded to with the appropriate notice announcement. A week prior to each meeting, a 22' x 27" poster was put up in several strategic viewing spots around Children's Hospital Medical Center and smaller notices in the elevators. These announcements brought inquiries from people employed in the CHMC complex, as well as visitors, with the result that some of these people have attended more than one meeting. It can be said people are finding CHMC to be a unique place to gain information about adoption and how to access the system.

Relative to the specific meetings, in September, the local public child welfare adoption and foster care units invited two families representing adopted children to speak about their experiences in applying for, being processed, and adjusting to

having an adoptable child placed in their care. Twenty-two adults attended this meeting as well as four children. No meeting was held in October, 1986, because of programming problems. In November, 1986, the film newly released by Adoption Options, a local group, was shown. This film provided a base to show how pregnant women need varied information to decision-make about a program of care for their yet-to-be born child. This film made mention of planning for the care of a normal as well as a child with special needs. The film was followed by a panel of four parents, each representing at least one adopted child with special needs. This meeting brought together 21 adults and 8 children. In December, 1986, the monthly meeting was cancelled because of the holidays. In January, 1987, the program topic was "The Home Study Process." Information was presented by representatives of both local public and private adoption resources; sixteen adults and five children were in attendance. Because of ice, the February meeting was cancelled. In March, 1987, a presentation about foreign adoptions was made. Eight adults got this information. In April, the documentary film, "The Debolts Stepping Out" was shown. Discussant was the Assistant Chaplain of Children's Hospital Medical Center, Cincinnati, who himself is a single parent and the father of 5 children, 4 of whom are developmentally delayed. Nine adults attended this meeting as well as three children. While a May meeting was in the making, it got cancelled due to the decision of various adoptive parents' support groups who banded together to have a 1 1/2 day workshop entitled, "Who Are the Children, Where Are the Families?" UACCDD did not want to be competitive with this offering, but instead chose to support the program.

The CAMI program topics were selected and developed dependant on verbal and written interests of the audience as learned through a monthly meeting registry. Each month the registry provides for additions to the mailing list and provides space for attendance to indicate the area of interest. To date, some have attended but one meeting, and a few have come to them all. As of May 1, 1987, the UACCDD adoption roster numbers approximately 62+--

Telephone inquiries are coming from outside of Cincinnati as to availability of the CAMI and information as to what's up in different adoption child-care agencies.

Now it is important to note that UACCDD is not in any way a child placement program. It does not intend to be known as a child placement business, nor referred to as a licensed child welfare agency. UACCDD is a speciality interdisciplinary service training center that networks with community-based resources of all types and families. UACCDD is not in conflict with the child welfare agencies caring for children, but a help

to them. The general feeling of the community-based agencies is "it's good to have another resource working to get children and adults together for a family life."

To help move children with special needs, who are free-for-adoption into an adoptive family situation, it was determined in June 1986, by Hamilton County Department of Human Services, and UACCDD, that the adoption/foster care social workers, and child care workers would need additional training to help them to look at their cases differently to better understand the needs of their specific children, possibly developmentally disabled. It also was agreed more effort was needed to be made media-wise to help the general public to learn more about children with special needs, and for a fact that some of them are available for adoption locally as well as outside of the area. Public relations efforts, schemes, including the press, Thursday's Child, T.V. programming, needed to be updated. People do know people who want to adopt children with special needs as known to clinicians. A lot of these people want to do this but have no idea of how to access the adoption systems, or they get frustrated working with different adoption programs because of one or an other barrier or the length of time it takes to get a child through the system.

Relative to in-service training, on December 8, 1986, the Director conducted a session about children with special needs as known to clinics, at the Hamilton County Department of Human Staff Development Meeting. On December 15, 1986, she was asked to speak at the Social Development Meeting for Adoption Workers at the Children's Home of Cincinnati. On December 19, 1986, she conferred with the Director of SUMA. This acronym stands for "Services to Unmarried Mothers and Adoption." SUMA's expertise is public relations work to make citizens' needs known through various media such as T.V. video taping, public service announcements, brochures, and workshops. SUMA's 23 member agencies look to it for publicity and assistance to serve children. Recognized for its community education program and data collecting, SUMA will provide computer services, if needed, for UACCDD's project. UACCDD is a charter member of SUMA, and the Director of Social Work has participated in a number of SUMA-sponsored workshops. She remains active doing committee tasks, and is a member of the Adoption Committee.

On January 8, 1987, the Director of Social Work met with the Adoption Social Work specialist at Jewish Family Service, Cincinnati, and Lutheran Social Service, Miami Valley, Cincinnati. On January 21, 1987, she met the Social Work/ Coordinator from OB/Gyn, University Hospital, Cincinnati. This is the community's public teaching hospital. On January 27, 1987, she met with the adoption specialist at Catholic Social Service, Southwest Ohio. Most recently, the Director of Social Work has met with the Chaplain, Children's Hospital, Cincinnati. The Chaplain himself is a single parent of 5 adopted children, several of whom have developmental disabilities, 4 of whom are

related as brothers and sisters. In addition to meeting with professionals, the Director of Social Work has been becoming aware of and getting known to various parents' support systems, OURS, Adoptions - Downs Syndrome Association, and APSO, Adopted Parents Support Organization. All professional and parent leaders of the groups informed about CCDD, HCDHS as they wish to speak out on behalf of the child with special needs, have become more aware of the developmentally disabled as viewed clinically, and have given support to CCDD's outreach.

Relative to media, since June 1986, considerable time has been devoted to how to get the word out on special needs adoption program to appeal to professionals and laymen, especially adults, interested in adoption. To date, letters have been written, notices circulated and posters made, plus there has been information passing a lot by word of mouth. People are curious. They are telephoning to inquire about upcoming meetings and are learning to plan ahead to attend monthly meetings. While additional media need to be employed, messages as they now exist, are spreading word about the special needs adoption program, "Consider Adoption," and its monthly information meeting is becoming known. This is due in part to the fact that a sign-up sheet is provided and from that sheet a mailing list is being developed. From the sign-up sheet also, a survey is mailed to each of those in attendance asking them to share their interests in adoption and what they would like to see happen in this particular project. The input has been promising and encouraging. The topics have been developed as a result of the adult professional/parent interest and apparent need.

So, not without flaws, University Affiliated Cincinnati Center for Developmental Disorders (UACCDD) is engaged in the brokerage business about adoptions for anyone who needs it. The CAMI sessions are off and running. The program is being implemented and situated in a clinical setting, and most of all it is this which makes it unique. Public information evenings held at CCDD within CHMC are recognized as worthwhile.

AIDS: A PUBLIC HEALTH CRISIS

Lawrence C. Shulman, M.S.W.

INTRODUCTION

I am pleased to be here at this annual Institute to participate with you in these exciting discussions. When Jerry St. Denis asked me to reflect with you on the rapidly accelerating issues generated during the past five years by Acquired Immunodeficiency Syndrome (AIDS), I eagerly accepted the challenge to bring together the knowledge, skills we have learned, and the concepts and dilemmas we have been struggling with at our hospital center and in the New York City region. My remarks are based on five intense years of experience and also extracted from a paper that Dr. Joanne Mantell and I just submitted for publication. AIDS has become a major public health problem and human crisis of unexpected dimensions (somewhat comparable to the dreaded influenza and polio epidemics before the development of vaccines)(1), straining health care and social service resources beyond capability in many communities. In the decades prior to 1981, the major infectious diseases were such "controllable" and "curable" illnesses as tuberculosis, "traditional" sexually-transmitted diseases, and rubella. Life-threatening infectious diseases were perceived to have been defeated by medical science, and in the United States, people rarely died from these illnesses. AIDS officially surfaced in June 1981, when it was identified as such by the United States Centers for Disease Control (CDC). The array of symptoms associated with AIDS is different from anything seen by the science. At the onset, public health professionals were generally unprepared for what has erupted into an epidemic of frightening proportion and destructiveness.

I'd like to discuss the AIDS crisis in the context of large New York City health care institutions which have treated nearly one-third of the cases in the United States, and from my own hospital's perspective. St. Luke's-Roosevelt Hospital Center has treated over 800 AIDS patients, and our current daily AIDS inpatient census averages between 65-75 patients, and grappling with the issues raised by this epidemic has become a daily necessity.

THE COST OF AIDS

The epidemic has taxed hospital, public health and community resources and underscored the need, once again, for coordinated long-term planning for a continuum of in-patient, out-patient and community support services. The cost of AIDS is high. In

1. There was an average of 15,822 cases of polio per year during 1951-1955 [1]. In 1918-1919, the influenza epidemic killed 400,000 Americans and millions worldwide. Measles, influenza, polio and tuberculosis are far more contagious than AIDS. 1985 more than 23,000 persons were hospitalized with AIDS in the U.S. The average total lifetime cost of hospitalization (for the first 10,000 cases of AIDS reported to the CDC) had been estimated to be about $147,000 per patient and this estimate did not include the costs of ambulatory care services. Recent projections estimate the cost per patient to be $26,000-$75,000. Data from St. Luke's-Roosevelt Hospital Center indicate that the daily cost of hospitalization for AIDS patients in 1985 was 38% higher than that of a comparably ill non-AIDS population.

In New York City, spending had been at an annual rate of $70-80 million dollars in municipal, state and federal funds, and the current yearly estimate is reported to be $400 million. Tentative 1991 projections are estimating more than a billion dollars a year in New York City alone.

With 74,000 new cases of AIDS conservatively projected for 1991, AIDS patients are expected to occupy more than 1% of all hospital beds across the United States and 3% in New York City. The cost of health care for AIDS patients in 1991 is projected to range from $8 billion to $16 billion dollars, but could easily reach $50-$100 billion dollars if less conservative estimates are used. With the expanded definition of AIDS by the CDC, as of July 1987 the number of identified cases will increase by about 20%, reaching a total of 325,000 cases by 1991. With prolongation of life as a result of large-scale use of experimental drugs, the costs of patient care will continue to escalate. The sheer numbers of patients will add further demands on scarce health and social care resources.

AIDS patients on a regular medical/surgical unit have been found to require about double the hours of nursing care provided to comparably ill medical and surgical patients in one New York City Hospital. In many hospitals, infection control procedures require that patients be maintained in isolation; thus, bed assignment flexibility is lost since most facilities do not have a sufficient number of private rooms. This creates economic problems for any institution serving significant numbers of persons with AIDS (PWAs) by reducing the available bed capacity (i.e., converting semi-private rooms to isolation rooms). In addition, negative perceptions of the hospital as an "AIDS treatment center" can reduce hospital utilization by non-AIDS patients and decrease hospital income, as has already occurred at one of our neighboring hospitals.

EPIDEMIOLOGY

As of May 1987, more than 35,000 cases of AIDS were reported in the United States, concentrated in large cosmopolitan communities of New York, San Francisco, Los Angeles, Miami, Houston and Newark. The CDC now indicates, however, that almost one-half of all reported new cases are occurring outside of the major urban epicenters.

Seventy-three percent of all AIDS cases occur among homosexual and bisexual men, of whom 11% are also intravenous (IV) drug users. An additional (17%) of AIDS cases are among the intravenous drug abuse population. The remainder are hemophiliacs, children of intravenous drug abusers (IVDAs), transfusion-associated, sex partners of people from a defined risk group, and a small group with no known risk factors in their history. 80% of all AIDS cases in females have occurred in women who had sex with IV drug abusers. Blacks and Hispanics are disproportionately represented, with about 40% of all AIDS cases in the United States occurring among these two ethnic minorities. About 75% of heterosexual cases thus far have been reported in Black and Hispanic patients. (See chart) in New York City, more than 55% of the AIDS cases are among Blacks and Hispanics and this poses a challenge for minority leadership and agencies together with the general community. The St. Luke's-Roosevelt Department of Social Work has been actively involved in working with many political, social and religious alliances and groups to address the crisis of AIDS.

An estimated 1.5 million people have been infected with the human immunodeficiency virus (HIV), but 2.7 - 3.0 million may be a more accurate estimate. The spread of AIDS has been dramatic, with reported cases increasing in all patient risk groups. Although the absolute numbers are increasing steadily, the rate of doubling has begun to slow down. (Currently, the rate doubles about every 13-14 months.) An estimated 25% of the people infected with the virus, however, will develop frank AIDS, and another 25%, AIDS-Related Complex (ARC) within 2-5 years. Even in the absence of overt systems, seropositive individuals can be carriers and are capable of transmitting HIV infection.

CLINICAL MANIFESTATIONS

AIDS has no known cure and no miracle drugs to halt its progression are yet available or in sight. It is a viral infection which triggers a broad spectrum of diseases. The immune system is compromised by HIV, isolated as the probable etiologic agent. This virus destroys the T-cell lymphocytes, which are the body's major mechanisms for fighting off disease. The immune system becomes depressed, and the individual is at increased susceptibility to other viruses, bacteria,

opportunistic infections and diseases. Kaposi's sarcoma (KS) is the most common neoplasm, and pneumocystis carinii pneumonia (PCP), the most prevalent opportunistic infection found in persons with AIDS. PCP has accounted for more than half of the reported AIDS- related deaths. AIDS has three major transmission routes: 1) through body fluids and waste products, including semen, blood and excretions, during intimate sexual contact, 2) sharing of contaminated needles and other drug paraphernalia, and 3) vertical transmission of AIDS (congenital or perinatal) from HIV infected women to the fetus during pregnancy and labor, to the baby at birth, and possibly during breast feeding.

The clinical spectrum of HIV infection is broad and variable, ranging from asymptomatic to rapidly progressive disease. The symptoms of AIDS and ARC are complex, systemic and ravaging to the body. AIDS has a 58% case fatality rate, with an average time from diagnosis to death of 18-24 months. As of the end of April 1987, more than 19,900 people had died from this disease in the United States.

AIDS is episodic and progressive in severity and AIDS patients typically require several hospitalizations over the course of illness. Care protocols may require treatment in an intensive-care unit and use of extensive life-support measures. Extensive and expensive drugs and nursing and respiratory therapy services may be required to stabilize the person with AIDS during acute illness episodes.

SOCIAL AND ORGANIZATIONAL IMPACT

The AIDS epidemic precipitated a community public health crisis in which the initial failure of the general community to respond appropriately and adequately forced the acute care hospital system to become the major provider of medical and psychosocial care, further straining these institutions at the very time they were confronted by a public policy environment of cost-containment, resource reduction and rationing. In many communities, alcohol and drug treatment centers reluctantly assumed a primary case management role for IVDAs with AIDS as well as a beginning role in risk-reduction education. In only one city in this country, San Francisco, spearheaded by the politically active and organized gay community, was there a unified public/private effort to deal with this epidemic and add needed resources to the fight. However, in other locales progressive policy had been impeded by indifference, fear or prejudice. Recent initiatives by the U.S. Public Health Service and the Robert Wood Johnson Foundation were catalytic in compelling the major AIDS epicenters to speed up the process of service development, delivery and coordination.

In the past year-and-a-half, a discernible shift from an acut hospital locus to a widening network of ambulatory care medical services and community-based social and health care supports has occurred. Many communities have begun to grapple with the impact of AIDS and some are developing the needed continuum of care services. Also, the medical community has gained both knowledge and comfort in treating more PWAs on an ambulatory care basis. From a public policy perspective, a major missing link in the continuum of services is the limited availability of long-term care options, especially the universal dearth of Residential Health Care Facility placements for PWAs. With increasing numbers of AIDS patients on various experimental therapies which prolong life, the problems of long-term care will be magnified.

AIDS Transmission in the Health Care Workplace

Occupational exposure to AIDS has presented a minimal risk to health care workers, so far. Studies of nearly 1,800 health care workers in AIDS-treating institutions indicate that other than two who developed AIDS through accidental needle sticks or direct contact with body fluids, no worker developed AIDS and only 26 were found to be HIV seropositive; of the 26, only three were not members of one of the high-risk groups. But as I speak with you today, there is talk of some disturbing new cases which CDC will soon report on of several health care workers who have become seropositive as a result of contact with body fluids and blood. We will need to study those cases carefully to determine whether appropriate infectious disease precautions were followed.

The most convincing evidence to date about casual transmission of AIDS (non-sexual and non-IV drug needle sharing) has been a recent longitudinal study of 101 households with an identified AIDS patient which indicated that no one sharing the household, in spite of close and continuing contacts, developed AIDS. This evidence is further reinforced by a recent Florida study of 45 adults with AIDS, their spouses, 109 children and 29 other adult household members. This research indicated that none of the 29 household members developed antibodies to HIV and none of the 90 seronegative children seroconverted.

Nevertheless, anxiety, fear and some hysteria of AIDS among health care workers still cause much concern, for example: food service workers refusing to enter the room of a PWA; nursing aides not wanting to change bed pans, urinals and linens; laundry workers refusing to handle linens of AIDS patients; dentists reluctant to treat dental problems of AIDS patients; EMS technicians (paramedics and firefighters) refusing to give mouth-to-mouth resuscitation to AIDS patients, or even to gay men, in trauma situations.

The AIDS epidemic has brought about organizational consciousness of the disease and patient care needs. Many health care institutions have targeted education programs to all levels of staff -- doctors, nurses, social workers, chaplains, housekeepers, x-ray technicians, dieticians, respiratory therapists, security guards, etc. -- to inform them about infection control precautions, mitigate fears of AIDS and alleviate work-related stresses.

Institutional responses to dealing with employees when they develop the first overt symptoms of AIDS have been variable. Organizations need to develop policies about how to handle employees who develop AIDS/ARC: job accommodation, involuntary sick leave, provision of disability benefits. Some organizations are now being sued for discrimination by employees (a physician, in one case) with HIV-spectrum disorders who have been fired. Health care facilities must also develop personnel strategies regarding staff who refuse to work with AIDS patients.

Community fears also have a dramatic impact on health care. This is visibly evidenced by the drastic reduction in the number of blood donors because of a convoluted fear of contracting AIDS, thus threatening the voluntary blood-supply system. Some people are banking their blood in hope of avoiding the risk of receiving a contaminated blood transfusion during medical or surgical emergencies. In a recent survey in Modern Healthcare, 29% of the sample believed it was somewhat likely that they could contract AIDS by being treated in a hospital that had AIDS patients.

Stresses on Health Care Workers

The impact of AIDS in the health workplace has been major in terms of the psychological toll on all levels of staff. Caregivers in hospitals have been physically and psychically overworked because most institutions do not have the resources to provide the necessary number of staff required to provide adequate quality control for patient services.

Health professionals have been overwhelmed by the daily confrontations with death and "do not resuscitate" orders for young people in the prime of their lives. Heavy physical nursing care requirements, combined with the inevitably losing battle with death, create high levels of exhaustion and stress. House staff, for example, expend much time doing extensive work-ups and performing invasive procedures which are not "easy" procedures for either physician or patient. Social workers spend hours daily to effect a reasonable plan to help an AIDS patient leave the acute facility, often with little or no success.

The prevalence of neurologic and psychiatric problem behaviors, and the AIDS Dementia Complex, have added a severe patient management burden. The complexity and array of symptoms, mood disturbances, cognitive deficits, psychomotor retardation and personality changes associated with AIDS complicate and challenge staff's abilities to manage patient care.

The social and economic impact of AIDS on the work force in terms of staff burnout and turnover has not been determined, and warrants empirical investigation. In the interim, experiential wisdom requires consideration of such staff-retention mechanisms as job rotation and accommodation, differential salaries, enhanced vacation benefits and active education and psychosocial support.

The intensity of services provided to AIDS patients diverts scarce resources available for other at-risk populations (especially under DRG pressures), reducing the hospital's efforts to provide broad-based coverage. With continued lack of resources predicted for the health care system, a kind of judgmental Social Darwinism can spread among beleagured health care institutions. Professional staff is placed in the position of judging social worth among patient populations to determine allocation of services.

The cost impact of the AIDS epidemic upon health and social agencies is not uniform across all groups of PWAs and certain salient differences in resource use have begun to emerge. While the basic costs of acute in-patient care are similar for IVDAs, gay/bisexual men and sex partners of high-risk individuals, the payment sources and reimbursement rates vary. The Health Care Financing Administration estimates that 40% of all AIDS patients are on Medicaid, but that the proportion may be as high as 69% in some metropolitan communities. The National Academy of Sciences, Institute of Medicine reported that the reimbursement rate for medicaid patients may be as much as 60% less than the actual costs of treatment.

In comparison with the gay population, IVDAs delay seeking medical care and present with fewer social and economic resources according to one study. Their health status is further compromised by disorders which are secondary to their chemical dependency. IV drug users thus require greater intensity of professional services within the hospital system and greater social support resources to effect a community care plan. IVDAs are not generally viewed as a preferred patient group by hospital staffs. IV drug users tend to have lower incomes and to be Medicaid recipients at time of diagnosis and need public funding throughout the illness course.

Because discharge plans are more difficult to resolve, IVDAs

often have protracted courses of hospitalization based on entitlement problems and dearth of resources rather than medical need. In many cities, a high proportion of IVDAs are homeless, and seeking services for this AIDS population may be frustrating to staff as well as management. More need exists, yet less money is expended on the group with the greatest potential for making the epidemic pandemic by spreading AIDS to the general population.

ORGANIZATIONAL RESTRUCTURING

The strains placed upon many acute care facilities as a result of AIDS, (within the context of scarce resources and hostile community values regarding the behaviors associated with the transmission of AIDS), have produced several organizational dilemmas. Hospitals and community service agencies benefit from mutual responsiveness and both were placed in the economically precarious and unanticipated emergency position of rapidly expending the scope and intensity of medical and social services. Living with the demands for services, the social agency and health care networks began to look at the range and type of services required to provide comprehensive, continuous quality care for AIDS patients.

Operational Support Mechanisms

Hospitals developed a number of mechanisms to address the workload and psychological burdens experienced by staff. In addition to educational programs, weekly support groups provide staff with a vechicle for ventilating fears and frustrations and managing patient crises. Some hospitals formed interdisciplinary teams to strengthen institutional policies, diagnostic and treatment services and provide coordinated supportive care to staff, patients, families and lovers. They may also oversee infection control protocols and develop educational programs for hospital staff. In New York City, the social work community organized a city-wide AIDS support network to discuss practice, continuity of care and system deficit issues.

At St. Luke's-Roosevelt Hospital Center, an AIDS Clinical Management Team addresses issues related to the clinical and psychosocial management of patients and staff. An AIDS Steering Committee formulates hospital policies, develops research guidelines and confronts issues of equity of third-party reimbursements for acute care hospitalization and ambulatory care services. Some hospitals mandate routine screening and assessment of all AIDS patients' need for social work and other clinical services. San Francisco General Hospital recruited the first special professional team to work with AIDS patients. Other hospitals have since developed specialized interdisciplinary AIDS teams. Volunteers are being recruited

and trained as friendly visitors, "buddies", crisis intervention workers and advocates for PWAs.

AIDS Treatment Centers and Dedicated AIDS Units

Two specialized hospitals for the treatment of AIDS have developed: St. Clare's Hospital and Health Center (New York City) and the Institute for Immunological Disorders (Houston, Texas). The public policy issue underlying such regionalized dedicated care centers or units is the civil liberties and public health ethics of isolating the care of the AIDS population. While there is historical precedence for this model of care (leper colonies and tuberculosis hospitals), we must carefully rethink the lessons learned to avoid repeating, for the AIDS patient, an unwarranted stigmatization. Specialized hospitals may be the first step toward community-demanded quarantine.

The high rate of hospital resource utilization characteristic of AIDS patients suggests, nonetheless, the need for altering traditional staffing patterns and patient unit configurations. A basic question is the appropriate balancing of resources in the face of this crisis. Hospitals which integrate AIDS patients with non-AIDS patients throughout the institution may pay a high price. The neurolgic and psychiatric behavior disturbances upset the operation of the unit as well as the tranquility of other patients. Will hospitals need to develop specialized medical/psychiatric units to serve patients with AIDS-related dementias? Are different units required for the effective care of PWAs with chemical dependency disorders? Additionally, the monopolization of professional staff resources by PWAs may deflect from the quantity and quality of care provided to the non-AIDS patients. These considerations are also pertinent to community-based public and voluntary health service agencies and the long-term care facilities.

Creation of in-patient AIDS units for patients in acute stage of illness allows for centralization and concentration of staff resources and expertise for those who need labor-intensive care. Attention must be directed to the special treatment approaches and problems involved in providing effective, quality care to patients with dementia or a history of IV drug use.

Hospitals' responsiveness to AIDS patients' specialized needs, however, may jeopardize the institution's existence. Segregation of patients into specialized AIDS units, albeit potentially cost- and care-efficient, will threaten the hospital's economic viability by lowering its occupancy rate if there is a mass defection of non-AIDS patients who go elsewhere to obtain medical care. If hospitals are non-responsive to PWAs, there may be violations of professional and institutional ethics and consequently, the potential for discrimination

suits. Insularity of AIDS patients could increase social ostracism and discrimination and conveys the message that AIDS is to be feared like leprosy and the plague.

ALTERNATIVES TO ACUTE CARE HOSPITALIZATION

Though not empirically tested, advances in the management of AIDS suggest that out-patient services can be effective and help sustain an improved quality of life for many PWAs. Although frequency of out-patient visits may be high, availability of community supports may decrease the number of hospitalizations and length of stay required. Comprehensiveness and continuity of care are critical following hospital discharge. The development of expanded ambulatory medical and supportive services are needed in the community.

Similarly, AIDS patients who require a Skilled Nursing Facility (SNF), for chronic or terminal care have become an additional economic burden for hospitals. In almost every community in this country, long-term care facilities are resistant to accepting PWAs. To date, in most states these facilities have not received higher reimbursement rates to compensate for the greater intensity of AIDS care. In some states, such as Maryland and New York, long-term care facilities are reimbursed according to levels of care provided. Also, fear of treating AIDS patients because of disease transmission concerns permeates this industry sector: staff, patients and patients' families. As with other "undesirable" populations, there is community resistance to establishing AIDS care facilities in their neighborhoods.

In the current climate of cost-containing DRGs, competitiveness and aggressive marketing to maintain high bed occupancy rates are evident. In most states, third-party payors, both private and governmental, have not reimbursed hospitals at higher rates despite the excessive costs of care resulting from intensive resource utilization. Consequently, hospitals have borne this burden and are losing significant amounts of money because of unreimbursed costs. In New York state, ten hospitals have been tentatively designated as AIDS centers and will consequently be eligible to receive an enhanced reimbursement rate. The high costs of hospitalization and the ability to treat patients ouside the acute care facilities should stimulate the creation of a new case payment mechanism that would permit the insurance industry to pay for out-of hospital care, such as hospice and home care services. for some patients, home care has not been a viable alternative because of inadequate community resources, lack of available significant others, inability to finance costs of professional in-home services, and delays in Medicaid authorization for heavy care. For many patient home care is equated with assurances of dignified humane care, a major concern in treating the scourge of AIDS.

It is believed by many health professionals that ambulatory care services are less costly than acute care. This remains to be proven. The lower costs cited for ambulatory or community-based care may reflect the provision of fewer services than are required, a shift of the cost burden of care to relatives or friends, or a diminished quality of services offered. There is no question, however, about the positive human values of providing services on an ambulatory basis.

Components of a service system should entail a full range of complementary services, including:

- .hospital-based and satellite ambulatory services to provide generalized and specialized acute and chronic levels of care and ongoing medical supervision
- .expanded home health care and skilled community nursing
- .hospice care (Such services are essential to people who lack significant social supports.)
- .long-term care facilities with appropriate levels of nursing and psychosocial care
- .foster care and day care services for children
- .multidisciplinary medical and psychosocial care by specialists in infectious diseases, oncology, pulmonary medicine, neurology, radiology, dermatology, psychiatry, social work, nursing, and nutrition.
- .dental care services
- .centralized case management and advocacy (which could be community or hospital-based) to integrate the range of services required by AIDS patients
- .health education of patients and significant others about infection control, prevention of HIV transmission
- .transportation to health and social services
- .volunteers to provide concrete services and emotional support
- .housing enrichment for people unable to obtain or maintain adequate housing.

The above issues reflect the complex range of problems which administrators and public health planners need to consider in developing an effective, efficient, humanistic quality care AIDS treatment program. They also point out some collaborative requirements between health and community-based agencies. The

knowledge gained in the large metropolitan areas can provide a basis for policy , planning and service delivery development in communities which now are beginning to experience the impact of the spreading AIDS epidemic.

The AIDS epidemic will not evaporate. All public, private and non-profit sectors of the health and social agency fields in each community will need to confront the urgency of these issues. Service providers will need to adopt catalytic roles in engaging consumer and self-help groups to organize a comprehensive community response to AIDS. With the escalating number of cases, a coordinated approach to policy, planning and financing is essential to prevent the fragmentation of services and the burden of care from falling on any one organization or sector of society. Civil liberties and ethical issues will need to be carefully examined. Only with such efforts can humanistic patient care in this public health crisis be achieved.

SELECTED BIBLIOGRAPHY

Afraids. 1985, The New Republic (October 14): 7-10

Amos, S., Cheung. L, Dickinson, D, and Golden, B. Effective discharge planning for AIDS patients. Continuing Care Coordinator (November/December 1985) 4: 22-26.

Anderson, H. 37% Fear Contracting AIDS in Hospital. Modern Healthcare, (November 3, 1985).

Arno, P.S. AIDS: A balancing act of resources. Business and Health (December 1986) 4: 20-24.

Beckham, M.M. and Rudy, E.B. Acquired immunodeficiency syndrome: Impact and implication for the neurological system. Journal of Neuroscience Nursing (February 1986) 18: 5-10.

Belmont, M.F., Mantell, J.E., and Spivak, H.B. Resource utilization by AIDS patients in the acute care hospital. Final Report, summary submitted to the Health Services Improvement Fund, Inc., Empire Blue Cross/Blue Shield (December 1985).

Boland, M.G. and Klug, R.M. AIDS: The implications for home care. MCN (November/December 1986) 11: 404-411.

Caputo, L. Dual diagnosis: AIDS and addiction. Social Work (July/August 1985) 361-364.

Centers for Disease Control. Acquired immunodeficiency syndrome: AIDS weekly surveillance report - United States. (August 18, 1986).

_____ Recommendations for preventing transmission of infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus in the workplace. Morbidity and Mortality Weekly Report (1985) 34: 682-686; 691-695.

_____ Update: Acquired immunodeficiency syndrome - United States. Morbidity and Mortality Weekly Report (December 12, 1986) 35(49): 757-761; 765-766.

_____ Update: Evaluation of human T-lymphotropic virus type III/lymphadenopathy-associated virus infection in health-care personnel - United States. Morbidity and Mortality Weekly Report (September 27, 1985) 34: 575-578.

_____ Update: Prospective evaluation of health-care workers exposed via the parenteral or mucous-membrane route to blood or body fluids from patients with acquired immunodeficiency syndrome - United States. Morbidity and Mortality Weekly Report (1985) 34: 101-103.

Detmet, W.M. and Lu, F.G. Neuropsychiatric complications of AIDS: A literature review. International Journal of Psychiatry in Medicine (1986-1987) 16(1): 21-29.

DeVita, V.T., Jr., Hellman S., and Rosenberg, S.A. AIDS: Etiology, Diagnosis, Treatment and Prevention. Philadelphia, Pennsylvania: J.B. Lippincott Company, 1985.

Fauci, A.S. Current issues in developing a strategy for dealing with the acquired immunodeficiency syndrome. Proceedings of the National Academy of Sciences (December 1986) 83: 9278-9283.

Gallo, R.C. The AIDS virus. Scientific American (January 1987) 256: 46-73.

Gonda, M.A. The natural history of AIDS. Natural History (May 1986) 95: 78-81.

Hardy, A., Rauch, K., Echenberg, D., Morgan W., Curran, J. The economic impact of the first 10,000 cases of AIDS in the U.S. Journal of the American Medical Association (1986) 255: 209-211.

Institute of Medicine, National Academy of Sciences. Confronting AIDS - Direction for Public Health, Health Care and Research. Washington, D.C.: National Academy Press, 1986.

Klass, P. The age-old fear of contagion arises when treating an AIDS patient. The New York Times (October 25, 1984) c2.

Lee, P.R. AIDS: Allocating resources for research and patient care. Issues in Science and Technology (Winter 1986) 2: 66-73.

Lopez, D. and Getzel, G.S. Strategies for volunteers caring for persons with AIDS. Social Casework: The Journal of Contemporary Social Work (January 1987) 47-53.

Luehrs, J., Orlebeke, E. and Merlis, M. AIDS and medicaid - the role of medicaid in treating those with AIDS. Public Welfare (Summer 1986) 44: 20-28.

Martin, J.P. Ensuring quality hospice care for the person with AIDS. Quality Review Bulletin (October 1986) 12: 353-358.

Mason, J.O. Statement on the development of guidelines for the prevention of AIDS transmission in the workplace. Public Health Reports (1986) 101(1): 6-8.

McCray, E. Occupational risk of the acquired immunodeficiency syndrome among health care workers. The New England Journal of Medicine (April 24, 1986) 314: 1127-1132.

McLaughlin, N. AIDS: Healthcare's deadly challenge. Modern Healthcare (December 5, 1986) 16: 28-29; 32-40; 42-43.

Morgan, W.M. and Curran, J.W. Acquired immunodeficiency syndrome: Current and future trends. Public Health Reports (September/October 1986) 101: 459-464.

Morin, S.F. and Batchelor, W.F. Responding to the psychological crisis of AIDS. Public Health Reports (January/February 1984) 99: 4-9.

Navia, B.A., Jordan, B.D., and Price, P.W. The AIDS dementia complex: I. Clinical features. Annals of Neurology (June 1986) 19: 517-524.

New York State Department of Health. 100 Questions and Answers about AIDS. (January 1, 1986) (For a free copy of this publication, call 1-800-462-1884 or write to P.O. Box 2000, Albany, N.Y. 12220).

Nursing care plan for persons with AIDS. Quality Review Bulletin (October 1986), 12: 361-365.

O'Hara, J.J., and Stangler, G.J. AIDS and the human services. Public Welfare (Summer 1986) 44: 8-13.

Richman, D. AIDS presents hospitals with liability concerns. Modern Healthcare (December 5, 1986) p. 38.

Rudensky, M. Long-term care facilities awaiting decisions on AIDS reimbursement. Modern Healthcare (July 18, 1986) p. 42.

Scitovsky, A.A. and Rice, D.P. Estimates of the direct and indirect costs of acquired immunodeficiency syndrome in the United States: 1985, 1986, and 1991. Public Health Reports (January/February 1987) 102: 5-17.

Seage, G.R., III, Landers, S., Barry, M.A., Groopman, J., Lamb, G.A. and Epstein, A.M. Cost of medical care for patients with acquired immunodeficiency syndrome (AIDS). JAMA in press.

Selwyn, P.A. AIDS: What is now known: II. Epidemiology. Hospital Practice (June 15, 1986) 127-164.

Tehan, C.B. Training volunteers in home care for patients with AIDS. Quality Review Bulletin (October 1986) 12: 359-365.

Viele, C.S., Dodd, M.J. and Morrison, C. Caring for acquired immune deficiency syndrome patients. Oncology Nursing Forum (May/June 1984) 11: 56-60.

Volberding, P.A. The clinical spectrum of the acquired immunodeficiency syndrome: Implications for comprehensive patient care. Annal of Internal Medicine (1985) 103: 729-733.

Waldman, S. The other AIDS crisis: Who pays for the treatment? The Washington Monthly (January 1986) 25-31.

Webster, M. Are AIDS patients getting good nursing care? Nursing Life (January/February 1987) 48-53.

SUMMARIZATION OF THE PROCEEDINGS
From "IMPLEMENTING A FORWARD PLAN: A PUBLIC HEALTH SOCIAL WORK CHALLENGE"

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As I sat in my room last evening preparing my summarization of the Institute's activities, I thought of many things ... happiness that I have come to be involved with such committed professionals as yourselves; validation of myself as a social work professional as a result of hearing all that we are doing in the field; yet an overwhelming sense that though I had so much paper, I could barely organize the morass lying on my bed for this summary, we have only touched the tip of the iceberg and could probably spend another four days discussing related and different problems. As a preface to my summary, I just want to say DARN! We are good! Let's keep it up in the future! We hardly ever congratulate ourselves enough for a job well done.

For those of you who have had the chance to read the Forward Plan and to try to put it together with what we have done here, I think it becomes clear that public health social work is much more comprehensive, sophisticated and complex in its approach to practice than it was even ten years ago. We can no longer focus only on patients and families.

In "The Conceptual Base for Public Health Social Work", Elizabeth Watkins stresses that we must use our skills which deal with systems change in order to solve the problems of poverty, malnutrition and unequal access to health care. We must also become skilled at administration, planning, evaluation and taking a leadership role in advocacy for legislative and policy changes. Our mission must remain to be improving the quality of life for our clients and society by destroying the barriers to services.

Alex Gitterman, in his opening address and summary of the Forward Plan, concluded with remarks about the notion of prevention and its implications for public health social work. I think his points were well taken and bear repeating in the context of this summary. Gitterman said that the primary objective of prevention..." is to forestall and anticipate some undesirable event or condition which might otherwise take place and spread..." (Gitterman, p.12)

Primary prevention has two aspects: (1) Specific protection and (2) Health promotion. Funding and thus professional

interests are primarily engaged in the specific protection aspect of prevention. Gitterman's concern, and a very important one in my estimation, was by emphasizing specific protection, we as social workers may be promising more than we can give or should be expected to give. He further suggests that defining our programs for funding or for practical purposes and promising to cure the ills of the world, we set ourselves up to fail. When we fail, our professional credibility diminishes and we further burden the populations we serve. We fail because the populations we serve are the most oppressed (the poorest, the most ill, the most dependent) and oppression is engrained in our society.

When dealing with these populations, Gitterman suggests that we need to re-examine the basic premises of prevention--specific protection and health promotion. They do not cover all of the problems. Gitterman suggests that social workers need to rediscover their roots in community organization or "environmental change" as a third alternative. He stated that it is essential for both instrumental accomplishments and for challenging the imbalance in power relations. Gitterman concluded by saying that participation and activism/advocacy can challenge the hopelessness, despair and apathy of the populations we deal with. I would add that this is something that we do well but do not realize we do well or market as a particular skill of our profession.

John Keil, in his lunch-time address on the "Creative Mystique," spoke to us about this very topic--"zigging in a zagging world," or, in my words--marketing an unpopular service in a complex world of horrendous social problems. Keil very creatively laid out for us a marketing plan for our profession. He suggested a five step plan to enhance our sometimes lacking public image which consisted of the following:

1. Defining the public perceptions or influences that may affect our creative thinking.

2. Defining our audience.

3. Defining what we want our audience to do.

4. Defining the core idea or what will get the audience to do what we want them to do, and

5. Defining why the core idea is valid, or what Keil referred to as the "Because" section.

In utilizing this five step approach, Keil suggested that we could arrive at a creative strategy that could positively influence our most adversarial audiences. He also suggested that the key to this creative brainstorming-type strategy is flexibility; another asset that social workers inevitably possess.

Everyone remembers the Hamm's Beer bear story that Keil concluded with. It was hysterically funny...we all laughed and sympathized with the interrupted production, the driver who contended with the 300 mile, "sick bear" trip, and so on. However, it struck me as I prepared this summary that social problems, like sick bears, require creative, flexible strategies, and with these strategies come our profession's improved marketability.

As I read the workshop summaries, the papers submitted, and assessed the workshops I attended myself, I found a lot of creativity, a lot of "zigging in a zagging world," and a lot of experience contending with "sick bears." The workshops were diverse, as our professional charge is diverse, but it was clear to me we have found that our traditional methods of practice are not the only answers to the complexities of the practice arena as we know it today.

In Monday's workshops, we covered topics from high-risk infants to the homeless and the issues of family violence. In the workshop, "Follow-up of High-Risk Infants and Their Families--Are they getting the Services they Need?," information was presented stressing the importance of the neonatal intensive care social worker to the family. Often this social worker is the family's one link to follow-up programs, support groups, community services, and to their getting the types of services for their infant that they need. We need to document better the social service needs of parents of high-risk infants once they leave the hospital, and to generate more data, in general, on these families.

Some of the important functions of the neonatal intensive care social worker in helping these families include the following:

1. Provide families with a safe outlet to express their fears.

2. Help families enhance past coping strategies that have been effective in other crises.

3. Help families identify needed community resources.

4. Be knowledgeable about disabled children's programs that may provide some of the needed services.

5. Remember that the family is the central caregiver over the long haul, work with them and empower them to become the primary "Case Manager" for the child.

Explanation was given for the new Education for the Handicapped Amendment, P.L. 99-457, which became effective in October, 1986. This legislation mandates services for infants,

ages 0-2, and provides for an Individualized Family Service Plan. Governors have already appointed the lead agency in most states who will implement and legislate. The hope is that services will be more interdisciplinary, better coordinated, and address the many needs of families of handicapped children, not just the medical needs of the child. A description was provided of the 99-457 legislation, the criteria, purpose, mandated services, and the political implications for various states. There will be a time for public comment in June. Social workers are encouraged to voice their views on the legislation.

The need for social workers to document information from families as to their experiences in caring for a handicapped child was also addressed. Claire Rudolph's study of 156 families interviewed by telephone approximately six months after they took the child home from the NICU was discussed. Categories she looked at included: Stress, feelings, medical problems, increased demand on the parents and how to cope with the future for these families. Her study showed that parents who had connected with social workers in the NICU were much better prepared to care for a handicapped child than those who did not connect. It also documented a tremendous need for more data that can supplement what we already know about these families.

In "Homeless Families, Children and Youth," attention was given to the characteristics of the homeless who represent the following groups:

-- Vietnam Veterans
-- Mentally handicapped
-- Physically disabled/chronically ill
-- Elderly
-- Unemployed
-- Single parents
-- Runaways
-- Chemically dependent
-- Immigrants
-- Transients

Further, it was stressed that homeless families are becoming a significant population suffering from extreme poverty and lack of affordable housing. Parents involved in homelessness have experienced numerous types of life disruption and need a consistent, concerted effort to break the cycle of homelessness.

Several excellent case examples were presented representing the Washington D.C. area shelter populations, needs and service issues. Discussion focused on a model of service delivery developed in Boston by Nancy Kaufman which defines the social worker as the key case manager in a continuum of services which looks at pre-homeless traumas, the emergency response to homelessness composed of shelter and meeting material and

financial needs as well as the phases of transition and stabilization. Transition and stabilization services range from housing assistance to coordinated support services. Extensive discussion was given to the level of practitioner necessary for this type of intervention as well as the sanctions of bureaucracies inhibiting services to homeless families.

In the workshop on "Family Violence," the issues involved in child abuse and domestic violence were addressed. In the segment on the emotional traumatization of children, four categories of abuse were reviewed: Physical, sexual, emotional and neglectful. Emotional abuse was identified as the most difficult to assess and define. The majority of abuse in all categories is done by parents with reported abuse in the "emotional" category being the highest with 90% of the abusers reported as the child's parents.

The effects of abuse are far-reaching and can disrupt the normal developmental process. Using Erikson's "Life Cycles" as an example, the potential disruption in each stage from birth through age 18 was reviewed beginning with an inability to develop a sense of trust in self and others and completing the adolescent cycle with an inability to integrate childhood experiences and move on to become stable adults.

There is a definable cycle of abuse with which we are all familiar--abused children becoming abusing parents. This is partially a question of judging what is "normal" by one's own experience. Abusive parents may have low self-esteem, frequently combined with high stress. It has been shown that stressful events have a direct correlation to the level of violence against children. This violence occurs across class, age, ethnic and racial groups. Indicators of child molestation and abuse were also covered in this workshop.

An important point which was also discussed at length is that society also victimizes children. On one level, societal issues such as infant mortality, homelessness, substance abuse and its effect on children (e.g. children born addicted, large number of abuse cases associated with addiction) and on another level, our band-aid solutions to clear evidence of child abuse. Frequently, society further abuses or neglects the child who has already been abused by his/her birth family.

In the segment of the Family Violence Workshop entitled "Masochism and Battered Women: Reality or Myth," discussion focused on the masochism label as another form of blaming the victim. It was emphasized that battering of women is <u>not</u> a new problem, but one that has recently been brought out into the open. Battering occurs across ethnic, religious and socioeconomic groups and is a seriously under-reported crime. The 1982 estimates showed that about two million women were battered annually, and this believed to be a conservative number since many cases go unreported.

Freudian theory and the related belief in women as masochists has led to a professional willingness to accept masochism as an explanation for battering. This continues to have a profound (negative) effect on those counseling battered women. The myth serves as a powerful block against needed change and blames the victim.

Attention was given as to why women stay in abusive situations. There are a variety of reasons: Fear of further and worse punishment to themselves, children and other family members; the value of keeping home and family together--a responsibility which society has placed on women primarily; the importance of being a "good" wife and mother, and the message that she would not be beaten if she was a "good" wife and mother. It was pointed out that women have no "political context" within which to view their abuse. They are isolated and alone.

It is not masochism that is common to battered women, but fear of more abuse, of failure, of depriving children of their father, fear of outside world -- the idea that if someone who loves you beats you, what can you expect from others? There is a learned helplessness which is the result but not the cause of the battering. Changes in perceptions are coming out slowly. Due to deep-rooted Freudian beliefs, battered women and masochism will continue to be linked.

During Tuesday's sessions, discussion continued concerning diverse populations with the overwhelming plea for increased social work interventions and sensitivity.

In "Sexuality, Childbearing and Family Planning Issues for Physically Challenged Women," we heard of the tremendous need for services to be developed for the specific issues of this population. Attention was paid to how disabled women are served or not served in the existing system and the sensitivity necessary for realistic services. Disabled women need factual information about their bodies, their abilities to conceive, genetic information and supportive systems which confirm their independence.

Disabled women, who are parenting, need physical access to child care areas, equipment to aid to child care, choices on homemaker type services and access to related programs. It was also emphasized that family planning services need to be viewed as a useful part of life-planning in general, as well as a choice the disabled women makes for herself.

"Case Management for Children with Special Health Needs: A Social Work Frontier for the Late 80's and Beyond" presented stimulating material on the arena of case management. The workshop covered the theoretical issues of why case management is important, definitions of case management, who identifies

clients and how that occurs, how case management is carried out and finally resulted in the presentation of a matrix analysis of case management. The matrix looked at the theoretical issues of case management such as definition of terms and models, barriers and obstacles to effective case management, benefits and outcomes, quality indicators, worker role and function, worker knowledge and skills and ended with a look at assessment tools and criteria for judging assessment tools.

A great deal of discussion focused on who should do case management and the obvious aspects of case management which are inherent in social work skills and training.

"Pregnant and Parenting Youth" brought attention to the issues involved in teen pregnancy, service utilization and the perceptions of teens involved in an Ohio community. Patterns have been observed showing the following: Young women have babies in order to feel needed and loved, and in 95% of the cases, they keep their babies; young men want to father in order to gain status with peers; teens measure themselves against their peers and what they see in the media. Pressure is placed on them to have sex while they consistently receive misinformation about their bodies and what sex really is about.

It was emphasized that as social workers, we need to get beyond the pregnancy problem itself and explore life options. We need to give accurate information emphasizing self-esteem, stress management and a systems approach to intervention which includes the churches, schools, families and the community.

In "Substance Use and Abuse", the effects of drugs on pregnant women were explored. An average pregnant woman takes approximately four drugs that are not vitamins during the first trimester when organs are developing. 80% of the drugs on the market today are not approved for use during pregnancy. Exposure to these drugs and various infections makes an infant high risk. By the 13th week, fetal growth/retardation can occur as well as functional defects. In each case, the fetus is unique and displays different symptoms. We do not consistently screen for these effects and the need for comprehensive screening is enormous.

"Special Needs--Special Approaches--Getting Children Together with Adoptive Parents" focused on two programs, one in Ohio and one in Alabama working with special needs adoptions.

The Alabama project sought to increase the adoption rates of special needs children, decrease the time they spend in foster care, decrease the number of adoption disruptions by providing supportive services to adoptive parents and to offer more post-placement services. It involved the efforts of multiple agencies such as Human Resources, a UAF and Children's Aid. The

benefits of the program were recruitment of 70 families and placement of 136 children, increased cooperation among agencies, reduced time spent in Temporary Custody and recognition of the need for continuous recruitment efforts.

The Ohio project is a UAF program focused on information dispersal regarding special needs children. It is a brokerage concept which is small and currently unfunded, but nevertheless making a positive impact.

Finally, it will be a long time before any of us forget Lawrence Shulman's discussion on "Aids: A Public Health and Organizational Crisis." He indicated statistically that within the next five years AIDS will impact on every level of practice. By 1991, there will be no community in this country untouched.

AIDS challenges us. There is a lack of resources, range of services and lack of long term care relative to the impact of increased symptomatology. The financial impact of AIDS is high in terms of length of care, intensity of the care needed and the systems involved. Yet the human cost is even more devastating. People with AIDS always die! The psychological toll on professionals is high.

Mr. Shulman reviewed current efforts in education, community responses, the public health and civil liberty issues involved in the AIDS crisis. He concluded by saying that the clinical management concept has put social workers in the forefront. We must look hard at the issues and take action.

In conclusion, this is a time of opportunity in public health social work. Our clients are needy, diverse and changing every day. There has been an all-encompassing aura of creativeness in this Institute. Let us seize the stimulation provided here, take it back to our practice arenas and make the future work for our profession. In the Forward Plan "Mission Statement," Juanita Evans concluded her article with a statement by Edward Cornish. I would like to leave that with you today...

"If anything is important, it is the future. The past is gone and the present exists only as a fleeting moment. Everything that we think and do from this moment on can affect the future. And, it is in the future that we shall spend the rest of our lives." And as John Keil would say, let's get out there and <u>DO</u>!